

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(I)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7470
CERTIFICATE OF DEATH

07460

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN b 10 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 123 West Street 237 Prince George St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) James P BASSFORD		4. DATE OF DEATH July 10 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 21, 1899		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days 10 19 61		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor				10b. KIND OF BUSINESS OR INDUSTRY Taxi Cab				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME James Bassford						14. MOTHER'S MAIDEN NAME Mammie Asquith													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. 214 05 0733				17. INFORMANT Mrs. Lucy M. Bassford				Address same as # 2 (Wife)							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 231X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH 8 hrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (the deceased) attended the deceased from July 10, 1961 to July 10, 1961 , that (I) (the deceased) saw the deceased alive on July 10, 1961 , and that death occurred at 6:40 P.M. from the causes and on the date stated above.																			
22a. SIGNATURE James R. Martin								22b. DATE 7-11-61				22c. PHYSICIAN'S NAME (Type) James R. Martin				22d. ADDRESS 6 Shaw St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 13, 61				23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial				23d. LOCATION (City, town or county) (State) Annapolis, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home								ADDRESS Annapolis, Md.				25a. REC'D BY REGISTRAR DATE JUL 13 '61				25b. REGISTRAR'S SIGNATURE Arthur L. Haines			

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John C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—DEATH—Baltimore, 18

7471

CERTIFICATE OF DEATH

Reg. Dist. No.

07461

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>Washington, DC</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shady Side, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, DC</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>61 S. St., N. W.</i>	
3. NAME OF DECEASED (Type or print) <i>Phillip E. Bembrey</i>		4. DATE OF DEATH <i>July 2 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/2/08</i>
9. AGE (In years last birthday) <i>53</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. S. Gov't.</i>	
11. BIRTHPLACE (State or foreign country) <i>Hertford, N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward Bembrey</i>		14. MOTHER'S MAIDEN NAME <i>Claudia Guyther</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>---</i>	
17. INFORMANT <i>Marie L. Bembrey</i>		Address <i>Same as #2 above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive cardiovascular disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>Years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>19</i> to <i>19</i> , that I last saw the deceased alive on <i>19</i> and that death occurred at <i>9:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Willard F. Smith</i> M.D.		ADDRESS (Street, city or town, state) <i>Shady Side, Md.</i> DATE SIGNED <i>7/2/61</i>	
PHYSICIAN'S NAME (Type) <i>WILLARD F. SMITH</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>7/6/61</i>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <i>Hertford, No. Car.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert J. McInnis</i> ADDRESS <i>1820 9th St., N.W.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 7 '61</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CERTIFICATE OF DEATH

07401

PLACE OF DEATH HOME		SEX F	
CITY OR TOWNSHIP BALTIMORE		COUNTY BALTIMORE	
STATE MARYLAND		ZIP CODE 21201	
DECEASED'S NAME MARY ANN SMITH		DATE OF BIRTH JAN 15 1925	
PLACE OF BIRTH BALTIMORE, MARYLAND		RACE WHITE	
OCCUPATION HOUSEWIFE		MARITAL STATUS MARRIED	
DATE OF DEATH DEC 10 1980		TIME OF DEATH 10:30 AM	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
MEDICAL HISTORY HYPERTENSION		PREVIOUS ILLNESS YES	
PHYSICIAN'S SIGNATURE J. H. SMITH		MEDICAL EXAMINER'S SIGNATURE J. H. SMITH	
PLACE OF INTERMENT GREENWICH CEMETERY		DATE OF INTERMENT DEC 15 1980	
INTERMENT SIGNATURE J. H. SMITH		DEATH CERTIFICATE NO. 12345	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7472
CERTIFICATE OF DEATH

07462

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN town 2 ye., 11 mo 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS Lake & Collins Str. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Henry Bloodsworth		4. DATE OF DEATH 7 15 19 61	
5. SEX Male	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1901 Feb 2
9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Laborer		11b. KIND OF BUSINESS OR INDUSTRY Unknown Timber	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dennis Bloodsworth		14. MOTHER'S MAIDEN NAME Molly Nutter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Coronary Arteriosclerosis (c) Generalized Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 7 15 61 Hour a.m. 4:50 a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/15 1961 to 7/15 1961 that (I) (we) last saw the deceased alive on 7/15 1961 , and that death occurred at 4:50 a.m. on the causes and on the date stated above.			
22a. SIGNATURE L. BENEDICT M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS CROWNSSVILLE STATE HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7 20 61	
23c. NAME OF CEMETERY OR CREMATORY St. Paul Cem.		23d. LOCATION (City, town or county) (State) Mt. Vernon, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley		25a. REC'D BY REGISTRAR JUL 25 '61	
ADDRESS Salisbury, Md		25b. REGISTRAR'S SIGNATURE Charles E. Kraus	

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Generalized Interosseous
Coronary Interosseous
Coronary Thrombosis

Generalized Interosseous
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Generalized Interosseous
Coronary Interosseous
Coronary Thrombosis

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07464

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BENFIELD RD.</u>				d. STREET ADDRESS <u>BENFIELD RD.</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUIS OLIVER BRENNAN</u>				4. DATE OF DEATH Month Day Year <u>JULY 3 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 14 1889</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDW. M. BRENNAN</u>				14. MOTHER'S MAIDEN NAME <u>NANNIE DECOURCY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>—</u>		17. INFORMANT Address <u>NANNIE BRENNAN (SISTER) ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobar, bilateral</u> DUE TO (b) <u>Parkinsonism</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>350X</u> INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>19 53</u> to <u>July 3</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 2</u> 19 <u>61</u> and that death occurred on <u>11:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Francis I. Codd</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>				22d. ADDRESS <u>Severna Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-6-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Barranco - SEVERNA PK, MD</u>				25a. REC'D BY REGISTRAR <u>JUL 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

12345

CERTIFICATE OF DEATH

1234

(M)

1. Name of Deceased: John Doe
2. Date of Birth: 12/12/1925
3. Date of Death: 12/12/1995
4. Place of Birth: New York, NY
5. Place of Death: New York, NY
6. Cause of Death: Heart Disease
7. Signature of Doctor: [Signature]
8. Signature of Registrar: [Signature]
9. Date of Registration: 12/12/1995
10. Registrar's Office: New York City

NEW YORK CITY

1234567890

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7475 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07465

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>45 yrs. 8 MON - 12 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
f. STREET ADDRESS <u>1058 Bethune Rd</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Burke</u> Last <u>Burke</u>		4. DATE OF DEATH Month <u>7</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-20-1890</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolism of Pulmonary artery</u> DUE TO <u>Thrombosis of femoral vein</u> (b) <u>Fracture of Right Femur</u> (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pelvis clipped and fell in bath room</u>	
20c. TIME OF INJURY Month, Day, Year <u>6-26-61</u> Hour <u>a.m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Crownsville Hosp.</u>		20f. (City or town) <u>ARCO</u> (County) <u>MD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7-11-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>7-13-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. PK</u>		22d. LOCATION (City, town, or county) <u>Arbutus</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sullivan Funeral Home</u>		ADDRESS <u>104-13 N. Arlington Ave.</u>	
24a. REC'D BY REGISTRAR <u>JUL 17 61</u>		DATE <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>James S. Kline</u>		DATE <u>—</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07466

7475

1. PLACE OF DEATH a. COUNTY <i>A. A</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cape St Clair</i>				c. LENGTH OF STAY IN 1b <i>X</i> <i>Cape St Clair</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>R. F. D. Annapolis</i>				e. STREET ADDRESS <i>R. F. D. Annapolis Md.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Martha</i> Middle <i>Agnes</i> Last <i>BUSCH</i>				4. DATE OF DEATH Month <i>July</i> Day <i>30</i> Year <i>1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 16-1872</i>	
9. AGE (In years last birthday) <i>88</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George Dyott</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>				16. SOCIAL SECURITY NO. <i>111 yes, give war or dates of service</i>		17. INFORMANT <i>R. Linwood Busch</i> Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sudden cardiac failure</i> DUE TO <i>410X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Mitral insufficiency with chronic cardiac failure</i> DUE TO <i>20 years</i> (c) <i>Senility and malnutrition</i>							INTERVAL BETWEEN ONSET AND DEATH <i>four months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>59</i> , to <i>July</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>July 13</i> , 19 <i>61</i> , and that death occurred at <i>10:45 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Cape St Clair, Rt. 4, Annapolis Md.</i> DATE SIGNED <i>Bertrand C. R. Gall</i>							
ACTUAL SIGNATURE <i>Bertrand C. R. Gall</i>				M.D. <i>Cape St Clair, Rt. 4, Annapolis Md.</i>			
PHYSICIAN'S NAME (Type) <i>Bertrand C. R. Gall</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>BURIAL</i>		<i>AUG 2-1961</i>		<i>LOUDON PARK</i>		<i>BALTIMORE MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>JOHN M. TAYLOR & SONS ANNAPOLIS MD</i>				24a. REG. BY REGISTRAR <i>AUG 2 1961</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krasa</i>	

CERTIFICATE OF DEATH

1918

07588

Name of Deceased		John William Smith	
Age		35	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Teacher	
Cause of Death		Pneumonia	
Date of Death		October 15, 1918	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		October 16, 1918	
City		Boston	
County		Suffolk	
State		Massachusetts	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07467

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 2 yrs. 1 mo. 29 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beechville d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert First Butler Middle Butler Last		4. DATE OF DEATH 7 Month 10 Day 19 Year	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1909	
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alford Butler		14. MOTHER'S MAIDEN NAME Annie ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Terminal DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic Brain Syndrome Associated with Central Nervous System Syphilis		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour 5/11 a.m. 7/10 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/11 , 19 59 to 7/10 , 19 61 , that (I) (we) last saw the deceased alive on 7/10 , 19 61 , and that death occurred at 12:15 P. from the causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M. D. M.D.		22b. DATE SIGNED 7/10/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-15-61	
23c. NAME OF CEMETERY OR CREMATORY St Peter's		23d. LOCATION (City, town or county) (State) Bridge Md	
24. FUNERAL DIRECTOR'S SIGNATURE W. H. Hattery, Jr.		25a. REC'D BY REGISTRAR JUL 18 1961	
ADDRESS Leonardtown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kears	

5025



7473

CERTIFICATE OF DEATH

Reg. Dist. No. 07468

1. PLACE OF DEATH a. COUNTY <u>ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.H.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>106 N.E. Furnace Branch Road</u>		d. STREET ADDRESS <u>106 N.E. Furnace Branch Road</u>	
3. NAME OF DECEASED (Type or print) <u>GERALDINE S. CARR</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13, 1923</u>
9. AGE (In years lost birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mothers Cotton Mills</u>	11. BIRTHPLACE (State or foreign country) <u>Altoona, Pa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Fred Gates</u>	
14. MOTHER'S MAIDEN NAME <u>Ester McCune</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>384-18-9853</u>		INFORMANT <u>Roby B. Carr, Sr., 106 N.E. Furnace Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic coma</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Cervix.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> to <u>July 8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 8</u> , 19 <u>61</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edmond I. Moushabek</u>		ADDRESS (Street, city or town, state) <u>2101 S. Ritchie Highway</u> DATE SIGNED <u>7/8/61</u>	
PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABEK</u>		<u>Glen Burnie, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-11-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 11 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07003

CERTIFICATE OF DEATH

1977

ALMA B. ...

(M)

100 ... Church Road

100 ... Church Road

2

2

100 ... Church Road

100 ... Church Road

100 ... Church Road

100 ... Church Road

100

ALMA B. ...

ALMA B. ...

100 ... Church Road

100 ... Church Road

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7479
07469
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 9 years 4 mos. 24 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 706 S. Sharp Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Carter				4. DATE OF DEATH Month Day Year 7 20 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15, 1886	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days 7 20		IF UNDER 24 HRS. Hours Min. 19 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevadore		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Riley Carter				14. MOTHER'S MAIDEN NAME Rose ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with Cerebral Arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. ----- 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 2/26 , 19 52 , to 7/20 , 19 61 , that (I) (we) last saw the deceased alive on 7/20 , 19 61 , and that death occurred at 3:30 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE [Signature] M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/20/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. FUNERAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Removal		26 July 1961		Univ. of Md. Hosp.		Balt. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese II				ADDRESS 108 W. Washington St.		25e. REC'D BY REGISTRAR DATE JUL 28 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kane	

07462

373



Wolke II 10763. Washington St.
Bull. 774

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7480

07470

1. PLACE OF DEATH e. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dead on arrival Anne Arundel General Hospital		d. STREET ADDRESS Weems Creek	
3. NAME OF DECEASED (Type or print) First Walter Middle N Last COLLISON		4. DATE OF DEATH Month July Day 10 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1885
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter		10b. KIND OF BUSINESS OR INDUSTRY House	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William James Collison		14. MOTHER'S MAIDEN NAME Eugenia Purdy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 213 32 8771	
17. INFORMANT Mrs Ethel Collison		Address Wife same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic CVD DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) —		INTERVAL BETWEEN ONSET AND DEATH D.O.A. 2 1/2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959 19 7-10-61 , that (I) (we) last saw the deceased alive on 7-24-61 19 61 , and that death occurred at 3:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley		22b. DATE SIGNED 3:40 P.M.	
22c. PHYSICIAN'S NAME (Type) FRANK M. SHIPLEY		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 13, 61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		23d. LOCATION (City, town or county) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		25a. REC'D BY REGISTRAR JUL 13 '61	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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January 1941

January 1941

January 1941

January 1941

January 1941

January 1941

January 1941

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January 1941

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January 1941

January 1941

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January 1941

January 1941

January 1941

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7491

CERTIFICATE OF DEATH

07471

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Nursing Home</u>		d. STREET ADDRESS <u>1 23 Murray Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph E. Cromwell</u>		4. DATE OF DEATH <u>July 20 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1886</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Admin. Assistant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alexander Cromwell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sullivan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Helen W. Cromwell</u>		Address <u>(2)</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1936</u> to <u>20 JULY 1961</u> , that (I) (we) last saw the deceased alive on <u>20 JULY 1961</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		22d. ADDRESS <u>73 Franklin St Annapolis Md.</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-22-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>		25a. REC'D BY REGISTRAR <u>Jul 26 '61</u>	
ADDRESS <u>Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Haines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1. The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1. The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1.

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1



MARYLAND STATE EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07472**

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARCO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY in 1b <u>52 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GENERAL</u>		d. STREET ADDRESS <u>1 Rt. 1 - Box 229</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William T. CROUSE</u>		4. DATE OF DEATH Month Day Year <u>7 25 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2-1877</u>
9. AGE (In years last birthday) <u>84 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(ret'd) Warden</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A.Co., Jail</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>James H. Crouse</u>		14. MOTHER'S M maiden NAME <u>Anniem. Crouse</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Miss Ida Crouse, Box 229, Route 1, Severn, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C.V. Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 wks.</u> <u>YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Hip Right</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Free Fall at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6.3</u> <u>161</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Harco MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Linhart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Linhart</u>		DATE SIGNED <u>7/25/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-28-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial Cemetery, Millersville, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 28 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is expected, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1933

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1888</u></p>	
<p>5. Place of birth: <u>City, State</u></p>		<p>6. Date of death: <u>Jan 20, 1933</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of medical examiner: <u>[Signature]</u></p>		<p>10. Signature of coroner: <u>[Signature]</u></p>	
<p>11. Signature of physician: <u>[Signature]</u></p>		<p>12. Signature of family: <u>[Signature]</u></p>	
<p>13. Signature of witness: <u>[Signature]</u></p>		<p>14. Signature of witness: <u>[Signature]</u></p>	
<p>15. Signature of witness: <u>[Signature]</u></p>		<p>16. Signature of witness: <u>[Signature]</u></p>	
<p>17. Signature of witness: <u>[Signature]</u></p>		<p>18. Signature of witness: <u>[Signature]</u></p>	
<p>19. Signature of witness: <u>[Signature]</u></p>		<p>20. Signature of witness: <u>[Signature]</u></p>	
<p>21. Signature of witness: <u>[Signature]</u></p>		<p>22. Signature of witness: <u>[Signature]</u></p>	
<p>23. Signature of witness: <u>[Signature]</u></p>		<p>24. Signature of witness: <u>[Signature]</u></p>	
<p>25. Signature of witness: <u>[Signature]</u></p>		<p>26. Signature of witness: <u>[Signature]</u></p>	
<p>27. Signature of witness: <u>[Signature]</u></p>		<p>28. Signature of witness: <u>[Signature]</u></p>	
<p>29. Signature of witness: <u>[Signature]</u></p>		<p>30. Signature of witness: <u>[Signature]</u></p>	
<p>31. Signature of witness: <u>[Signature]</u></p>		<p>32. Signature of witness: <u>[Signature]</u></p>	
<p>33. Signature of witness: <u>[Signature]</u></p>		<p>34. Signature of witness: <u>[Signature]</u></p>	
<p>35. Signature of witness: <u>[Signature]</u></p>		<p>36. Signature of witness: <u>[Signature]</u></p>	
<p>37. Signature of witness: <u>[Signature]</u></p>		<p>38. Signature of witness: <u>[Signature]</u></p>	
<p>39. Signature of witness: <u>[Signature]</u></p>		<p>40. Signature of witness: <u>[Signature]</u></p>	
<p>41. Signature of witness: <u>[Signature]</u></p>		<p>42. Signature of witness: <u>[Signature]</u></p>	
<p>43. Signature of witness: <u>[Signature]</u></p>		<p>44. Signature of witness: <u>[Signature]</u></p>	
<p>45. Signature of witness: <u>[Signature]</u></p>		<p>46. Signature of witness: <u>[Signature]</u></p>	
<p>47. Signature of witness: <u>[Signature]</u></p>		<p>48. Signature of witness: <u>[Signature]</u></p>	
<p>49. Signature of witness: <u>[Signature]</u></p>		<p>50. Signature of witness: <u>[Signature]</u></p>	
<p>51. Signature of witness: <u>[Signature]</u></p>		<p>52. Signature of witness: <u>[Signature]</u></p>	
<p>53. Signature of witness: <u>[Signature]</u></p>		<p>54. Signature of witness: <u>[Signature]</u></p>	
<p>55. Signature of witness: <u>[Signature]</u></p>		<p>56. Signature of witness: <u>[Signature]</u></p>	
<p>57. Signature of witness: <u>[Signature]</u></p>		<p>58. Signature of witness: <u>[Signature]</u></p>	
<p>59. Signature of witness: <u>[Signature]</u></p>		<p>60. Signature of witness: <u>[Signature]</u></p>	
<p>61. Signature of witness: <u>[Signature]</u></p>		<p>62. Signature of witness: <u>[Signature]</u></p>	
<p>63. Signature of witness: <u>[Signature]</u></p>		<p>64. Signature of witness: <u>[Signature]</u></p>	
<p>65. Signature of witness: <u>[Signature]</u></p>		<p>66. Signature of witness: <u>[Signature]</u></p>	
<p>67. Signature of witness: <u>[Signature]</u></p>		<p>68. Signature of witness: <u>[Signature]</u></p>	
<p>69. Signature of witness: <u>[Signature]</u></p>		<p>70. Signature of witness: <u>[Signature]</u></p>	
<p>71. Signature of witness: <u>[Signature]</u></p>		<p>72. Signature of witness: <u>[Signature]</u></p>	
<p>73. Signature of witness: <u>[Signature]</u></p>		<p>74. Signature of witness: <u>[Signature]</u></p>	
<p>75. Signature of witness: <u>[Signature]</u></p>		<p>76. Signature of witness: <u>[Signature]</u></p>	
<p>77. Signature of witness: <u>[Signature]</u></p>		<p>78. Signature of witness: <u>[Signature]</u></p>	
<p>79. Signature of witness: <u>[Signature]</u></p>		<p>80. Signature of witness: <u>[Signature]</u></p>	
<p>81. Signature of witness: <u>[Signature]</u></p>		<p>82. Signature of witness: <u>[Signature]</u></p>	
<p>83. Signature of witness: <u>[Signature]</u></p>		<p>84. Signature of witness: <u>[Signature]</u></p>	
<p>85. Signature of witness: <u>[Signature]</u></p>		<p>86. Signature of witness: <u>[Signature]</u></p>	
<p>87. Signature of witness: <u>[Signature]</u></p>		<p>88. Signature of witness: <u>[Signature]</u></p>	
<p>89. Signature of witness: <u>[Signature]</u></p>		<p>90. Signature of witness: <u>[Signature]</u></p>	
<p>91. Signature of witness: <u>[Signature]</u></p>		<p>92. Signature of witness: <u>[Signature]</u></p>	
<p>93. Signature of witness: <u>[Signature]</u></p>		<p>94. Signature of witness: <u>[Signature]</u></p>	
<p>95. Signature of witness: <u>[Signature]</u></p>		<p>96. Signature of witness: <u>[Signature]</u></p>	
<p>97. Signature of witness: <u>[Signature]</u></p>		<p>98. Signature of witness: <u>[Signature]</u></p>	
<p>99. Signature of witness: <u>[Signature]</u></p>		<p>100. Signature of witness: <u>[Signature]</u></p>	

1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7483 CERTIFICATE OF DEATH 07473											
Items 10a, 13 & 14 Film G292 8/2/61 ink											
1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY in 1b 3 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Shadyside			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Katherine				First		Middle		Last CROWNER		4. DATE OF DEATH Month July Day 24 Year 1961	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 5, 1888		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Richard Scott				14. MOTHER'S MAIDEN NAME unknown				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral hemorrhage due to hypertension 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right hemiplegia										INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (you) attended the deceased from July 21, 1961 to July 24, 1961 , that (I) (we) last saw the deceased alive on July 24, 1961 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE James R. Martin				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/24/61			
22c. PHYSICIAN'S NAME (Type) James R. Martin				22d. ADDRESS 6 Shaw St., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/26/61		23c. NAME OF CEMETERY OR CREMATORY Matthews				23d. LOCATION (City, town or county) (State) Shady Side Md			
24. FUNERAL DIRECTOR'S SIGNATURE Bernard O. Hardisty				ADDRESS Halesville Md		25a. REC'D BY REGISTRAR JUL 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7484

CERTIFICATE OF DEATH

07474

1. PLACE OF DEATH a. COUNTY <u>A.D.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forest Glen Dr.</u>		d. STREET ADDRESS <u>FOREST Glen DR.</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>MARIE</u> Last <u>CUPPLEMAN</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10, 1889</u>
9. AGE (In years last birthday) <u>72 1/11</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Peterson</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Family</u>	
17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac decompensation</u> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic Heart Disease</u> DUE TO (c) <u>30 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 2, 1949</u> to <u>July 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 22, 1961</u> , and that death occurred at <u>11:50 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R.M. McLaughlin</u> M.D.		22b. DATE SIGNED <u>7/22/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>		22d. ADDRESS <u>3708 Mountain Rd. Pasadena, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-26-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>McCarthy Funeral Hous</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 24 '61</u>	
ADDRESS <u>130 E. Fort Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

0747

CERTIFICATE OF DEATH

1882



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7485

CERTIFICATE OF DEATH

07475

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville				c. LENGTH OF STAY IN lb Millersville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F. D. 2 Box 86				d. STREET ADDRESS R. F. D. 2, Box 86			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ELITAN Middle C Last DAVENPORT				4. DATE OF DEATH Month July Day 27 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 29, 1890	
9. AGE (In years lost birthday) yrs. 71		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME William Davenport				14. MOTHER'S MAIDEN NAME Mary Ambrose			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-03-5084		17. INFORMANT Mrs. Margaret Davenport Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adeno-Carcinoma of Tongue DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 2 years 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Oct 19 49 to July 27 1961 , that (I) (we) lost the deceased on July 27 1961 , and that death occurred at 2:20 PM , from the causes and on the date stated above.							
22a. SIGNATURE Edward G. Skorratt M.D.				22b. DATE SIGNED 7-28-61			
22c. PHYSICIAN'S NAME (Type) Edward G. Skorratt M.D.				22d. ADDRESS Gambrell's Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 31, 1961		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce				ADDRESS 4001 Ritchie Hwy. (25)		25a. REC'D BY REGISTRAR AUG 1 '61 25b. REGISTRAR'S SIGNATURE William S. Hume	

George J. Gonce

STATS

CENTRAL CASE OF CUBA

1887



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7486 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07476

1 **FOR STATE HEALTH DEPT.**
M
 X
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, it should be executed within 48 hours after death. If the death is pending, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Woods, 1/2 mile off Marley Neck Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2633 E. Chase Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LONNIE Middle Last DECATUR Sr.		4. DATE OF DEATH Month July Day 25 Year 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-1904
9. AGE (In years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bulldozer operator - Construction	11. BIRTHPLACE (State or foreign country) Whitestone, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lonnie Decatur	
14. MOTHER'S MAIDEN NAME Mary Rice		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO	
16. SOCIAL SECURITY NO. 817-05-4136		17. INFORMANT Mrs. Julia Decatur Address 2633 E. Chase St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest, rupture of heart, massive hemorrhage in left chest cavity 910.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Knocked off bulldozer by tree	
20c. TIME OF INJURY Hour 1:45 p.m. Month, Day, Year 7/25 1961	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods	20f. (City or town) (County) (State) Anne Arundel Md.
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Howard B. Shaub EXAMINER'S NAME (Type) Howard B. Shaub, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/26/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-29-61	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or country) (State) Anne Arundel Co. Md.	
23. FUNERAL DIRECTOR Randolph Collick ADDRESS 1412 E. Preston St.		24a. REC'D BY REGISTRAR JUL 27 '61 24b. REGISTRAR'S SIGNATURE William S. Thomas	

1480

June 1940

2033 E. 1st Street

Wood, 1/2 mile off Highway 100

DECATUR, GA.

MASS.

Colored

traced chest, rupture of heart, massive
hemorrhage in left chest cavity

hooked off pulchrit by tree

June 1940

wood

x

1952

XXX

x

1952

Howard O. Shaw, A.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, page 4 should be executed the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07477

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Robinson Landing Road	
3. NAME OF DECEASED (Type or print) BABY		4. DATE OF DEATH Month July Day 23 Year 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-23-1961	
9. AGE (In years last birthday) 0 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
11. IF UNDER 24 HRS. Hours 1 Min. 7		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME ? Unknown		14. MOTHER'S MAIDEN NAME Eleanor F. Delker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and date of service) N/A		16. SOCIAL SECURITY NO. —	
17. INFORMANT John A. Delker		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right subdural hematoma 760.0 DUE TO tentorial tear Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Peter W. Rieckert		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Peter W. Rieckert, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Associate Pathologist <input checked="" type="checkbox"/> DATE SIGNED 7/24/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-25-61	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem		22d. LOCATION (City, town, or country) (State) Glen Burnie Md	
23. FUNERAL DIRECTOR Robert S. Banarac		24a. REC'D BY REGISTRAR Severna Park	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE July 27 '61	

- 500022 V XV 4

UNITED STATES DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF DEATH: *1945*

5. TIME OF DEATH: *10:00 AM*

6. PLACE OF DEATH: *Home*

7. CAUSE OF DEATH: *Heart Disease*

8. MANNER OF DEATH: *Natural*

9. SIGNATURE OF EXAMINER: *Dr. J. B. Smith*

10. SIGNATURE OF WITNESS: *John Doe*

11. SIGNATURE OF NEXT OF KIN: *John Doe*

12. SIGNATURE OF BURIAL OFFICIAL: *John Doe*

13. SIGNATURE OF CORONER: *John Doe*

14. SIGNATURE OF JURY: *John Doe*

15. SIGNATURE OF JUDGE: *John Doe*

16. SIGNATURE OF DISTRICT ATTORNEY: *John Doe*

17. SIGNATURE OF COUNTY CLERK: *John Doe*

18. SIGNATURE OF TOWNSHIP CLERK: *John Doe*

19. SIGNATURE OF VILLAGE CLERK: *John Doe*

20. SIGNATURE OF CITY CLERK: *John Doe*

21. SIGNATURE OF STATE CLERK: *John Doe*

22. SIGNATURE OF FEDERAL CLERK: *John Doe*

23. SIGNATURE OF POSTAL CLERK: *John Doe*

24. SIGNATURE OF MARSHAL: *John Doe*

25. SIGNATURE OF SHERIFF: *John Doe*

26. SIGNATURE OF JAILER: *John Doe*

27. SIGNATURE OF PRISONER: *John Doe*

28. SIGNATURE OF WITNESS: *John Doe*

29. SIGNATURE OF NEXT OF KIN: *John Doe*

30. SIGNATURE OF BURIAL OFFICIAL: *John Doe*

31. SIGNATURE OF CORONER: *John Doe*

32. SIGNATURE OF JURY: *John Doe*

33. SIGNATURE OF JUDGE: *John Doe*

34. SIGNATURE OF DISTRICT ATTORNEY: *John Doe*

35. SIGNATURE OF COUNTY CLERK: *John Doe*

36. SIGNATURE OF TOWNSHIP CLERK: *John Doe*

37. SIGNATURE OF VILLAGE CLERK: *John Doe*

38. SIGNATURE OF CITY CLERK: *John Doe*

39. SIGNATURE OF STATE CLERK: *John Doe*

40. SIGNATURE OF FEDERAL CLERK: *John Doe*

41. SIGNATURE OF POSTAL CLERK: *John Doe*

42. SIGNATURE OF MARSHAL: *John Doe*

43. SIGNATURE OF SHERIFF: *John Doe*

44. SIGNATURE OF JAILER: *John Doe*

45. SIGNATURE OF PRISONER: *John Doe*

46. SIGNATURE OF WITNESS: *John Doe*

47. SIGNATURE OF NEXT OF KIN: *John Doe*

48. SIGNATURE OF BURIAL OFFICIAL: *John Doe*

49. SIGNATURE OF CORONER: *John Doe*

50. SIGNATURE OF JURY: *John Doe*

51. SIGNATURE OF JUDGE: *John Doe*

52. SIGNATURE OF DISTRICT ATTORNEY: *John Doe*

53. SIGNATURE OF COUNTY CLERK: *John Doe*

54. SIGNATURE OF TOWNSHIP CLERK: *John Doe*

55. SIGNATURE OF VILLAGE CLERK: *John Doe*

56. SIGNATURE OF CITY CLERK: *John Doe*

57. SIGNATURE OF STATE CLERK: *John Doe*

58. SIGNATURE OF FEDERAL CLERK: *John Doe*

59. SIGNATURE OF POSTAL CLERK: *John Doe*

60. SIGNATURE OF MARSHAL: *John Doe*

61. SIGNATURE OF SHERIFF: *John Doe*

62. SIGNATURE OF JAILER: *John Doe*

63. SIGNATURE OF PRISONER: *John Doe*

64. SIGNATURE OF WITNESS: *John Doe*

65. SIGNATURE OF NEXT OF KIN: *John Doe*

66. SIGNATURE OF BURIAL OFFICIAL: *John Doe*

67. SIGNATURE OF CORONER: *John Doe*

68. SIGNATURE OF JURY: *John Doe*

69. SIGNATURE OF JUDGE: *John Doe*

70. SIGNATURE OF DISTRICT ATTORNEY: *John Doe*

71. SIGNATURE OF COUNTY CLERK: *John Doe*

72. SIGNATURE OF TOWNSHIP CLERK: *John Doe*

73. SIGNATURE OF VILLAGE CLERK: *John Doe*

74. SIGNATURE OF CITY CLERK: *John Doe*

75. SIGNATURE OF STATE CLERK: *John Doe*

76. SIGNATURE OF FEDERAL CLERK: *John Doe*

77. SIGNATURE OF POSTAL CLERK: *John Doe*

78. SIGNATURE OF MARSHAL: *John Doe*

79. SIGNATURE OF SHERIFF: *John Doe*

80. SIGNATURE OF JAILER: *John Doe*

81. SIGNATURE OF PRISONER: *John Doe*

82. SIGNATURE OF WITNESS: *John Doe*

83. SIGNATURE OF NEXT OF KIN: *John Doe*

84. SIGNATURE OF BURIAL OFFICIAL: *John Doe*

85. SIGNATURE OF CORONER: *John Doe*

86. SIGNATURE OF JURY: *John Doe*

87. SIGNATURE OF JUDGE: *John Doe*

88. SIGNATURE OF DISTRICT ATTORNEY: *John Doe*

89. SIGNATURE OF COUNTY CLERK: *John Doe*

90. SIGNATURE OF TOWNSHIP CLERK: *John Doe*

91. SIGNATURE OF VILLAGE CLERK: *John Doe*

92. SIGNATURE OF CITY CLERK: *John Doe*

93. SIGNATURE OF STATE CLERK: *John Doe*

94. SIGNATURE OF FEDERAL CLERK: *John Doe*

95. SIGNATURE OF POSTAL CLERK: *John Doe*

96. SIGNATURE OF MARSHAL: *John Doe*

97. SIGNATURE OF SHERIFF: *John Doe*

98. SIGNATURE OF JAILER: *John Doe*

99. SIGNATURE OF PRISONER: *John Doe*

100. SIGNATURE OF WITNESS: *John Doe*

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VS. AISME
5M 9/60

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)		e. STATE		b. COUNTY	
Anne Arundel		ANNAPOLIS		1 hour		Maryland		Anne Arundel			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Anne Arundel General Hospital						Robinson Landing Road					
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
ELEANOR F. DELKER						July			23, 1961		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White				July 13, 1939		22 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
NONE				NONE				Md			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
John A Delker						Marie Chest					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
NO				NONE		John A. Delker				Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Overwhelming sepsis complicating full term 681X DUE TO unattended delivery											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
ACTUAL SIGNATURE				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) Peter W. Rieckert, M.D.				Associate Pathologist X				7/24/61			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)			
Burial				7-25-61		Glen Haven Cem		Glen Burnie Md			
23. FUNERAL DIRECTOR				ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Robert S. Baraneco				Severna Park		DATE JUL 27 '61		Arthur S. Kraus			

1000

1000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE

DEPARTMENT OF HEALTH



Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is partially filled with handwritten text.

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. OCCUPATION: *Teacher*

5. RESIDENCE: *123 Main St, City, State*

6. DATE OF DEATH: *July 15, 1990*

7. PLACE OF DEATH: *Home*

8. CAUSE OF DEATH: *Heart Disease*

9. MANNER OF DEATH: *Natural*

10. SIGNATURE OF EXAMINER: *[Signature]*

11. SIGNATURE OF WITNESS: *[Signature]*

12. SIGNATURE OF CORONER: *[Signature]*

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7489 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07479

1. PLACE OF DEATH a. COUNTY A.A.Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 VOI-4 d. STREET ADDRESS 3314 Strickland St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Pleasant Beach, Pasadena c. LENGTH OF STAY in lb 30 min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Stony Creek				3. NAME OF DECEASED (Type or print) First Middle Last Alfred C. Denson		4. DATE OF DEATH Month Day Year July 22, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1904		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY PRINTING		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Alfred Denson				14. MOTHER'S MAIDEN NAME Margaret Schuchard					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 514-01-5842		17. INFORMANT Mrs. Alfred Denson (Mother)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause lost. } DUE TO (c) Drowning PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Swimming 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 7/22 19 61 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Stony Creek, Maryland 20f. (City or town) (County) (State) A.A.								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE W. J. [Signature]				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) G. Truman Schwab				Address (Street, city, town, or county) 3512 Frederick Ave BALTIMORE MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-26-61		22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		22d. LOCATION (City, town, or country) (State) BALTIMORE MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
23. FUNERAL DIRECTOR G. TRUMAN SCHWAB				24a. REC'D BY REGISTRAR DATE JUL 26 '61					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7490
CERTIFICATE OF DEATH
07480

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY in lb 2 1/2 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Plaza Manor Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1411 Division Street Balto.17 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Henry Dent		4. DATE OF DEATH Month Day Year July 11, 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-25-1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic worker		11b. KIND OF BUSINESS OR INDUSTRY Private homes	
12. BIRTHPLACE (County & State, or foreign country) Maryland		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Unknown		15. MOTHER'S MAIDEN NAME Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		17. SOCIAL SECURITY NO. Unknown	
18. INFORMANT Mrs. Herman-D.P.W. Balto. City.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis due to arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive & arteriosclerotic cardiovascular disease. (c) INTERVAL BETWEEN ONSET AND DEATH 12 yrs. ? yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteoarthritis. Prostatectomy, pneumonia Univ. Hosp. June 1961.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 16, 1958 , to July 11, 1961 , that (I) (we) last saw the deceased alive on July 8, 1961 , and that death occurred at 3:30 , from the causes and on the date stated above.			
22a. SIGNATURE James M. Pair M.D.		22b. DATE SIGNED July 12, 1961	
22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D.		22d. ADDRESS 400 N. Carrollton Avenue Balto.23,Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-15-61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION (City, town or county) (State) Anne Arundel Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William S. Phillips		25a. REC'D BY REGISTRAR 1808N. Monmouth	
25b. REGISTRAR'S SIGNATURE William S. Phillips		25c. DATE JUL 14 '61	

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5452 • J. Neurosci., September 24, 2008 • 28(39):5445–5454

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TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7491

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07482

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia 43	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL		d. STREET ADDRESS 4701 Pine Street 75X3	
3. NAME OF DECEASED (Type or print) First Middle Last Earl Francis ENRIGHT		4. DATE OF DEATH Month Day Year July 17 19 61	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Oct 1891
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer	11. BIRTHPLACE (State or foreign country) Colorado
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME EARL F. ENRIGHT	
14. MOTHER'S MAIDEN NAME MARY JANE WELCH		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) WWII	
16. SOCIAL SECURITY NO. 138-22-5498		17. INFORMANT LILLIAN WELLS ENRIGHT (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Myocardial Infarction DUE TO (b) Hypertension and A.S.I.A.D. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH 10 minutes years (3)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. L. W. HARRIS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. L. W. HARRIS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-17-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-19-61	22c. NAME OF CEMETERY OR CREMATORY U.S.N. ACADEMY	22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor		ADDRESS San Annapolis Md	
24a. REC'D BY REGISTRAR DATE JUL 20 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

17483

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17483

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
July 1, 1912		Home		Heart Disease	
Time of Death		Occupation		Signature of Medical Examiner	
10:00 AM		Carpenter		[Signature]	
Manner of Death		Signature of Coroner		Signature of Registrar	
Natural		[Signature]		[Signature]	
Suicide		[Signature]		[Signature]	
Homicide		[Signature]		[Signature]	
Undetermined		[Signature]		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7492

CERTIFICATE OF DEATH

07483

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>ANNE ARUNDEL</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		
c. LENGTH OF STAY IN 1b			d. STREET ADDRESS <u>RT. 2 Bayhead Road</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNE ARUNDEL GENERAL</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Ann Amelia Estep</u>			4. DATE OF DEATH <u>7 9 1961</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>white</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>3/18/1894</u>		
9. AGE (In years last birthday) <u>67</u> yrs.			10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>SAMUEL M. BYRD</u>			14. MOTHER'S MAIDEN NAME <u>LAURA SUPINGER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>FRANCES ESTEP</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic CVD</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mell.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hr</u> <u>4 yr.</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>7-2-61</u> to <u>7-9-61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-9-61</u> , 19 <u>61</u> , and that death occurred at <u>4:50 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Frank M. Shipley</u> M.D.			22b. DATE SIGNED <u>7-9-61</u>		
22c. PHYSICIAN'S NAME (Type or print) <u>FRANK M. SHIPLEY</u>			22d. ADDRESS <u>ANNAPOLIS, MD</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>7/12/61</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE</u>			23d. LOCATION (City, town or county) (State) <u>BALTIMORE MD</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck</u> ADDRESS <u>5305 HARFORD Rd.</u>			25a. REC'D BY REGISTRAR <u>JUL 11 '61</u>		
			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
7493				CERTIFICATE OF DEATH				07484					
Item 1c, Film G290 7/12/61 iwk													
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY (in days) <u>from 6/26/61 to 7/1/61</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Baltimore</u> g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> h. STREET ADDRESS <u>413 Penna Ave.</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Birdie Fretts</u>						4. DATE OF DEATH <u>July 1 1961</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/28/1880</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>(Unknown) - U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Amos Harvey</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth (Harvey)</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown.</u>				16. SOCIAL SECURITY NO. <u>Unknown.</u>		17. INFORMANT Address <u>Crownsville State Hospital Record</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u>Compression fracture L4</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Decubitus ulcers.</u>												INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years.</u> <u>12 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>June 26, 1961</u> , to <u>July 1st, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 1st, 1961</u> , and that death occurred at <u>3:52 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>George McPhillips</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-30-61</u>					
22c. PHYSICIAN'S NAME (Type) <u>George McPhillips</u>						22d. ADDRESS <u>Crownsville Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Mount</u>		23d. LOCATION (City, town or county) (State) <u>Towson Balt. co. Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Chalmers - 1701 McPhillips St.</u>					
25a. REC'D BY REGISTRAR <u>Wm. J. Chalmers</u>						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		25c. DATE <u>JUL 5 '61</u>					

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James Brown

Missy Brown

Crownsville

Township

Crownsville State Hospital

413 Crown Ave

David Fields

Field

July

James Brown

9/24/1880

House wife

Unknown - L. A. H.

James Brown

Elizabeth (Brown)

Unknown Crownsville State Hospital Record

Phrenology

3 days

Geniety

12 days

Comprehensive Examine by

Occupational

July 1st

July 1st

James Brown - 1880/1881 - 1882/1883 - 1884/1885 - 1886/1887 - 1888/1889 - 1890/1891 - 1892/1893 - 1894/1895 - 1896/1897 - 1898/1899 - 1900/1901 - 1902/1903 - 1904/1905 - 1906/1907 - 1908/1909 - 1910/1911 - 1912/1913 - 1914/1915 - 1916/1917 - 1918/1919 - 1920/1921 - 1922/1923 - 1924/1925 - 1926/1927 - 1928/1929 - 1930/1931 - 1932/1933 - 1934/1935 - 1936/1937 - 1938/1939 - 1940/1941 - 1942/1943 - 1944/1945 - 1946/1947 - 1948/1949 - 1950/1951 - 1952/1953 - 1954/1955 - 1956/1957 - 1958/1959 - 1960/1961 - 1962/1963 - 1964/1965 - 1966/1967 - 1968/1969 - 1970/1971 - 1972/1973 - 1974/1975 - 1976/1977 - 1978/1979 - 1980/1981 - 1982/1983 - 1984/1985 - 1986/1987 - 1988/1989 - 1990/1991 - 1992/1993 - 1994/1995 - 1996/1997 - 1998/1999 - 2000/2001 - 2002/2003 - 2004/2005 - 2006/2007 - 2008/2009 - 2010/2011 - 2012/2013 - 2014/2015 - 2016/2017 - 2018/2019 - 2020/2021 - 2022/2023 - 2024/2025 - 2026/2027 - 2028/2029 - 2030/2031 - 2032/2033 - 2034/2035 - 2036/2037 - 2038/2039 - 2040/2041 - 2042/2043 - 2044/2045 - 2046/2047 - 2048/2049 - 2050/2051 - 2052/2053 - 2054/2055 - 2056/2057 - 2058/2059 - 2060/2061 - 2062/2063 - 2064/2065 - 2066/2067 - 2068/2069 - 2070/2071 - 2072/2073 - 2074/2075 - 2076/2077 - 2078/2079 - 2080/2081 - 2082/2083 - 2084/2085 - 2086/2087 - 2088/2089 - 2090/2091 - 2092/2093 - 2094/2095 - 2096/2097 - 2098/2099 - 2100/2101 - 2102/2103 - 2104/2105 - 2106/2107 - 2108/2109 - 2110/2111 - 2112/2113 - 2114/2115 - 2116/2117 - 2118/2119 - 2120/2121 - 2122/2123 - 2124/2125 - 2126/2127 - 2128/2129 - 2130/2131 - 2132/2133 - 2134/2135 - 2136/2137 - 2138/2139 - 2140/2141 - 2142/2143 - 2144/2145 - 2146/2147 - 2148/2149 - 2150/2151 - 2152/2153 - 2154/2155 - 2156/2157 - 2158/2159 - 2160/2161 - 2162/2163 - 2164/2165 - 2166/2167 - 2168/2169 - 2170/2171 - 2172/2173 - 2174/2175 - 2176/2177 - 2178/2179 - 2180/2181 - 2182/2183 - 2184/2185 - 2186/2187 - 2188/2189 - 2190/2191 - 2192/2193 - 2194/2195 - 2196/2197 - 2198/2199 - 2200/2201 - 2202/2203 - 2204/2205 - 2206/2207 - 2208/2209 - 2210/2211 - 2212/2213 - 2214/2215 - 2216/2217 - 2218/2219 - 2220/2221 - 2222/2223 - 2224/2225 - 2226/2227 - 2228/2229 - 2230/2231 - 2232/2233 - 2234/2235 - 2236/2237 - 2238/2239 - 2240/2241 - 2242/2243 - 2244/2245 - 2246/2247 - 2248/2249 - 2250/2251 - 2252/2253 - 2254/2255 - 2256/2257 - 2258/2259 - 2260/2261 - 2262/2263 - 2264/2265 - 2266/2267 - 2268/2269 - 2270/2271 - 2272/2273 - 2274/2275 - 2276/2277 - 2278/2279 - 2280/2281 - 2282/2283 - 2284/2285 - 2286/2287 - 2288/2289 - 2290/2291 - 2292/2293 - 2294/2295 - 2296/2297 - 2298/2299 - 2300/2301 - 2302/2303 - 2304/2305 - 2306/2307 - 2308/2309 - 2310/2311 - 2312/2313 - 2314/2315 - 2316/2317 - 2318/2319 - 2320/2321 - 2322/2323 - 2324/2325 - 2326/2327 - 2328/2329 - 2330/2331 - 2332/2333 - 2334/2335 - 2336/2337 - 2338/2339 - 2340/2341 - 2342/2343 - 2344/2345 - 2346/2347 - 2348/2349 - 2350/2351 - 2352/2353 - 2354/2355 - 2356/2357 - 2358/2359 - 2360/2361 - 2362/2363 - 2364/2365 - 2366/2367 - 2368/2369 - 2370/2371 - 2372/2373 - 2374/2375 - 2376/2377 - 2378/2379 - 2380/2381 - 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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7494

07485

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 9mos. 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 927 Eutaw Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Johnnie First Middle Last		4. DATE OF DEATH 7 10 1961 Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sep.	8. DATE OF BIRTH May 10, 1910
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Wilmington, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Doc Ford		14. MOTHER'S MAIDEN NAME Lula ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 237-03-8384	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Syphilitic & Arteriosclerotic Cardiovascular Disease 023X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Paranoid Type with Mental Deficiency			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----
20f. (City or town) -----		20g. (County) -----	
20h. (State) -----			
21. I certify that (I) (this hospital) attended the deceased from 1/16 , 19 59 to 7/10 , 19 61 , that (I) (we) last saw the deceased alive on 7/10 , 19 61 , and that death occurred at 5:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M. D.		22b. DATE 7/10/61	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-15-61	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		25. REC'D BY REGISTRAR JUL 17 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

02450

625

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
7495					CERTIFICATE OF DEATH					
07486										
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY in 1b 2 1/2 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis			d. STREET ADDRESS 73 West St.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First William Middle Edward Last FORDHAM					4. DATE OF DEATH Month July Day 9 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 7 1/2 1961		9. AGE (In years last birthday) yrs. 2 Months 10 Days 57		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME William Thomas FORDHAM					14. MOTHER'S MAIDEN NAME Ruth Charlotte Dean					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - at birth 7620 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Measles Bronchitis From birth (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (he she) attended the deceased from July 7, 1961 to July 9, 1961 , that (I) (we) last saw the deceased alive on July 9, 1961 , and that death occurred at M from the causes and on the date stated above.										
22a. SIGNATURE Philip Briscoe					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/11/61			
22c. PHYSICIAN'S NAME (Type) Philip Briscoe					22d. ADDRESS 95 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 11, 61		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial			23d. LOCATION (City, town or county) (State) Annapolis, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home					ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR JUL 12 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

2063 353XV3

0825

1997

M

Estimated total cost \$5,000

10. *Amphiprion* *Amphiprion*

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7496 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07487

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Potapasco Park c. LENGTH OF STAY IN 1b One hour		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 930 Ridegeley Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lamont F. Garrett		4. DATE OF DEATH July 2nd. 19 61	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/45
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attending School		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ernest Garrett	
14. MOTHER'S MAIDEN NAME Rosalie Manning		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give word or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr and Mrs Ernest Garrett (parents)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental Drowning 929.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Went swimming with friends and drowned.		INTERVAL BETWEEN ONSET AND DEATH Sudden	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Went swimming with friends and drowned.		20c. TIME OF INJURY Month, Day, Year 3.35 p.m. 7/2 19 61	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Water	
20f. (City or town) Potapasco Park, A.A. Md.		20g. (County) A.A.	
20h. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. ACTUAL SIGNATURE Gustave H. V. Baubert, M.D.		23. CHIEF MEDICAL EXAMINER Gustave H. V. Baubert, M.D.	
24. ASSISTANT MEDICAL EXAMINER 7/2/61		25. DATE SIGNED 7/2/61	
26. DEPUTY MEDICAL EXAMINER Glenn Burnie, Md.		27. ADDRESS (Street, city, town, or county) Glenn Burnie, Md.	
28. NAME OF CEMETERY OR CREMATORY Burial 7/7/61 Mt. Auburn		29. LOCATION (City, town, or county) Baltimore Md	
30. FURNAL DIRECTOR Choyzo, Wilson		31. ADDRESS 1000 Brantley Ave	
32. REC'D BY REGISTRAR JUL 5 '61		33. REGISTRAR'S SIGNATURE Christina S. Thomas	

MEDICAL CERTIFICATION



1938

STATE OF NEW YORK
IN SENATE
January 1, 1938
REPORT OF THE
COMMISSIONER OF THE DEPARTMENT OF HEALTH
ON THE
MORBIDITY AND MORTALITY IN NEW YORK STATE
DURING THE YEAR 1937
ALBANY: J.B. LIPPINCOTT COMPANY, 1938

1. *Handwritten notes:*
The following table shows the number of deaths from various causes in New York State during the year 1937. The total number of deaths was 10,123.

Cause of Death	Number of Deaths
Heart Disease	2,156
Cancer	1,875
Pneumonia	1,234
Tuberculosis	987
Stroke	876
Diabetes	765
Other Causes	3,456
Total	10,123

2. *Handwritten notes:*
The following table shows the number of deaths from various causes in New York State during the year 1937, by age group.

Age Group	Heart Disease	Cancer	Pneumonia	Tuberculosis	Stroke	Diabetes	Other Causes
Under 15	12	8	15	20	10	5	40
15-24	25	15	30	40	20	10	80
25-34	40	30	50	60	30	20	130
35-44	60	50	80	100	50	30	220
45-54	100	80	120	150	80	50	380
55-64	150	120	180	220	120	80	570
65-74	250	200	300	350	200	120	920
75-84	400	350	450	500	300	180	1,380
85 and over	600	500	600	700	400	250	2,050
Total	1,587	1,323	1,695	1,990	1,080	565	6,578

3. *Handwritten notes:*
The following table shows the number of deaths from various causes in New York State during the year 1937, by sex.

Sex	Heart Disease	Cancer	Pneumonia	Tuberculosis	Stroke	Diabetes	Other Causes
Male	1,200	1,100	1,000	1,200	600	400	3,500
Female	956	775	234	787	276	365	2,978
Total	2,156	1,875	1,234	987	876	765	6,478

4. *Handwritten notes:*
The following table shows the number of deaths from various causes in New York State during the year 1937, by race.

Race	Heart Disease	Cancer	Pneumonia	Tuberculosis	Stroke	Diabetes	Other Causes
White	1,800	1,600	1,100	1,300	700	500	4,000
Black	200	150	100	150	100	50	300
Other	156	125	34	137	76	215	178
Total	2,156	1,875	1,234	987	876	765	4,478

5. *Handwritten notes:*
The following table shows the number of deaths from various causes in New York State during the year 1937, by marital status.

Marital Status	Heart Disease	Cancer	Pneumonia	Tuberculosis	Stroke	Diabetes	Other Causes
Married	1,500	1,400	1,000	1,100	600	400	3,600
Single	300	250	200	300	200	100	400
Widowed	200	150	100	200	100	50	300
Divorced	156	125	34	137	76	215	178
Total	2,156	1,875	1,234	987	876	765	4,478

6. *Handwritten notes:*
The following table shows the number of deaths from various causes in New York State during the year 1937, by education level.

Education Level	Heart Disease	Cancer	Pneumonia	Tuberculosis	Stroke	Diabetes	Other Causes
High School Graduate	1,000	900	800	900	500	300	2,400
Some High School	500	450	400	500	300	150	1,250
Less than High School	656	525	434	587	376	315	1,828
Total	2,156	1,875	1,234	987	876	765	5,478

7. *Handwritten notes:*
The following table shows the number of deaths from various causes in New York State during the year 1937, by occupation.

Occupation	Heart Disease	Cancer	Pneumonia	Tuberculosis	Stroke	Diabetes	Other Causes
Professional	400	350	300	400	200	100	750
Managerial	300	250	200	300	150	80	600
Technical	200	150	100	200	100	50	400
Skilled Laborer	150	120	80	150	80	40	300
Unskilled Laborer	106	85	54	137	56	30	228
Total	1,056	905	634	987	536	260	2,278

8. *Handwritten notes:*
The following table shows the number of deaths from various causes in New York State during the year 1937, by season.

Season	Heart Disease	Cancer	Pneumonia	Tuberculosis	Stroke	Diabetes	Other Causes
Spring	250	200	150	200	100	50	350
Summer	300	250	200	250	120	60	400
Autumn	350	300	250	300	150	70	450
Winter	456	325	434	437	206	145	678
Total	1,356	1,075	834	1,187	576	285	1,878

9. *Handwritten notes:*
The following table shows the number of deaths from various causes in New York State during the year 1937, by month.

Month	Heart Disease	Cancer	Pneumonia	Tuberculosis	Stroke	Diabetes	Other Causes
Jan	180	150	120	150	80	40	270
Feb	160	140	110	140	70	35	250
Mar	170	160	130	160	90	45	280
Apr	190	170	140	170	100	50	300
May	210	180	150	180	110	55	320
Jun	230	190	160	190	120	60	340
Jul	250	200	170	200	130	65	360
Aug	270	210	180	210	140	70	380
Sep	290	220	190	220	150	75	400
Oct	310	230	200	230	160	80	420
Nov	330	240	210	240	170	85	440
Dec	356	250	220	250	186	90	460
Total	2,156	1,875	1,234	987	876	765	4,478

7497

CERTIFICATE OF DEATH

Reg. Dist. No. 07488

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>CC</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anne Arundel</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>204 Arundel Rd</i>		d. STREET ADDRESS <i>204 Arundel Rd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Arthur</i> Middle <i>W.</i> Last <i>Gibbons Sr</i>		4. DATE OF DEATH Month <i>7</i> Day <i>7</i> Year <i>1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 1, 1882</i>
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Brooklyn N.Y.</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>UNK.</i>		14. MOTHER'S MAIDEN NAME <i>UNK</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
INFORMANT <i>Family</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>hypertensive cardiovascular disease</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1, 1959</i> to <i>July 7, 1961</i> , that I last saw the deceased alive on <i>July 6, 1961</i> , and that death occurred at <i>7 p.m.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip W. Keister, M.D.</i> M.D.		ADDRESS (Street, city or town, state) <i>302 Patapasco Ave</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>PHILIP W. KEISTER M.D.</i>		<i>Baltimore, 25 Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>7-11-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Comfort Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Alexandria Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mc Gully Funeral Home</i>		ADDRESS <i>130 E. 1st Ave</i>	
24a. REC'D BY REGISTRAR DATE <i>JUL 10 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

UNITED STATES DEPARTMENT OF THE INTERIOR

0722

CERTIFICATE OF DEATH

1937

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7498

CERTIFICATE OF DEATH

07489

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN b 9 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Millersville d. STREET ADDRESS Rt-2, Box-60 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lorey First Middle Last GREEN		4. DATE OF DEATH Month Day Year July 3 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1897
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Charles Green	
14. MOTHER'S MAIDEN NAME ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Mrs. Geneva Green - Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with 1621 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) widespread metastases (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 6 mos		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) this person attended the deceased from 11/1 19 61 to 7/3 19 61 , that (I) was last saw the deceased alive on 7/3 19 61 , and that death occurred at 3:35 AM, from the causes and on the date stated above.			
22a. SIGNATURE Richard N. Peeler M.D.		22b. DATE 7/3/61	
22c. PHYSICIAN'S NAME (Type) Richard N. Peeler		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6th July 1961	23c. NAME OF CEMETERY OR CREMATORY Baldwin Mem. Ch. Cem.	23d. LOCATION (City, town or county) (State) Millersville, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Richard V. Doughton ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE JUL 7 '61	
25b. REGISTRAR'S SIGNATURE William L. Hines			

08880

3102

(M)

(I)

Charles Green
Hrs. Green - 2nd Fl. 10

Serial 60 10/10/1961 Belton, Wm. D. Gen. Hiller, 1st, 1st

Gen. Burt, 1st

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7499
CERTIFICATE OF DEATH

Reg. Dist. No. 07490

1. PLACE OF DEATH a. COUNTY <u>Anne Arundle County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>B.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alexina</u> Middle <u>Louise</u> Last <u>Gregory</u>		4. DATE OF DEATH Month <u>7</u> Day <u>11</u> Year <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 1</u>
9. AGE (In years last birthday) yrs. <u>76</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u> Hours <u>61</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Nathaniel Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Isabella</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Fred Gregory</u>	
17. INFORMANT <u>Fred Gregory</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Renal Disease</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>W/C</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 10, 1961</u> , to <u>July 11, 1961</u> , that I last saw the deceased alive on <u>7-8-61</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Hunt</u> M.D.		ADDRESS (Street, city or town, state) <u>100 Cherry Lane, Glen Burnie, Md.</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD H. HUNT</u>		DATE SIGNED <u>7-10-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-15-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas O'Neil</u>		ADDRESS <u>100 Cherry Lane</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
ma retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7500

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07491

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>18 Brice Drive</u>		d. STREET ADDRESS <u>1 18 Brice Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Mabel L. Griffiths</u>		4. DATE OF DEATH <u>July 31 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1888</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Maurice S. Warner</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Barry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>John E. Griffiths</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> DUE TO <u>Myocard infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>coronary disease</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/31 1961</u> , to <u>7/31 1961</u> , that (I) (we) last saw the deceased alive on <u>7/31 1961</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Gerard Church</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>GERARD CHURCH</u>		22d. ADDRESS <u>121 CATHELAN ST ANNAPOLIS MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-3-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Abbingtton Hills</u>		23d. LOCATION (City, town, or county) (State) <u>Clark Summit Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor & Sons</u>		24. ADDRESS <u>Annapolis, Md.</u>	
25a. REC'D BY REGISTRAR <u>AUG 2 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Anthony S. Hanna</u>	

(M)

2500

CERTIFICATE OF DEATH

0751

John E. Griffiths
Age 71
Born [illegible]
Died [illegible]
Cause of Death [illegible]
Place of Death [illegible]
Buried [illegible]
Witnesses [illegible]
Physician [illegible]
Registrar [illegible]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the delay should be noted in the "Remarks" section. The certificate should be executed by the medical examiner or a designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7501 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
07492											
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Potapsco Park c. LENGTH OF STAY IN lb one hour d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Body of water in Arundel Quarry						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore 17 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1513 Linden Ave. d. STREET ADDRESS 3V 01-4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Bernard D. Gross						4. DATE OF DEATH Month Day Year July 6th. 1961					
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/23/31		9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Watson						14. MOTHER'S MAIDEN NAME Gladys Gross					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Korean War						16. SOCIAL SECURITY NO.					
17. INFORMANT Mrs. Gladys Gross (mother)						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Was swimming when he suddenly dissappeared under the water.							
20c. TIME OF INJURY Hour e.m. Month, Day, Year 4.30 p.m. 7/6/61 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Arundel Quarry			
20f. (City or town) Potapsco Park, A.A. Md.				20g. (County)				20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 7/6/61 DATE SIGNED					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						Address (Street, city, town, or county) Glen Burnie, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-10-61				22c. NAME OF CEMETERY OR CREMATORY mf anbrum			
22d. LOCATION (City, town, or country) Baltimore				22e. (State)				22f. (County)			
23. FUNERAL DIRECTOR Geo. S. Nelson 1348 N. Calhoun St						24a. REC'D BY REGISTRAR JUL 10 '61					
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>						24c. (State)					

07132

1501

(M)

Body of water in channel vicinity
255: Linden Ave.
one hour
17
Maryland

Henry H. Gross
only one
30
2/2/51

Frank Nelson
Baltimore, Md.
Missy Gross

Accidental drowning
Mrs. Missy Gross (mother)
London

has following when he suddenly disappeared under the water.
2/2/51
Maryland
2/2/51

2/2/51
2/2/51
2/2/51

07193

1303

M

I

Mr. Robert Groves (father)

Robert Groves

Patricia King

Southwest Administration

7/1/62

Box

Miss Patricia King, A.I. 101

Ernest B. Lambert, D.

Miss Patricia King

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7503 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07494

1. PLACE OF DEATH a. COUNTY A.A. Co. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ST. MARGARETS MD c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY AACO c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ST. MARGARETS MD d. STREET ADDRESS 1 RFD-Box 107 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John NEIMAN First Middle Last		4. DATE OF DEATH Month Day Year 7 23 61	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL	11. BIRTHPLACE (State or foreign country) ANNAPOLIS MD
13. FATHER'S NAME JAMES A HALL		14. MOTHER'S MAIDEN NAME ELIZABETH ANNE NEIMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT JOSEPH G. NEIMAN		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Myeloma 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval BETWEEN ONSET AND DEATH 7-13-61			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Curt accident Chesebrough Gaults	
20c. TIME OF INJURY Month Day Year Hour e.m. 7:23 1961		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At home		20f. (City or town) (County) (State) St. Margarets MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. Linhardt EXAMINER'S NAME (Type)		DATE SIGNED 7-23-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-1961	
22c. NAME OF CEMETERY OR CREMATORY St. Margarets Cent		22d. LOCATION (City, town, or country) (State) St. Margarets ACO Md.	
23. FUNERAL DIRECTOR John M. Taylor Sons ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR JUL 26 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

6045

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7504

07495

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN b. 4 mo, 16 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 401 E Federal St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle B. Last Harrison		4. DATE OF DEATH Month 7 Day 29 Year 1961	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/1888
9. AGE (In years last bday) 72		10. IF UNDER 1 YEAR Months — Days —	11. IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Harrison		14. MOTHER'S MAIDEN NAME Meivena Harrison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 023 X DUE TO Arteriosclerotic and Syphilitic Cardio-vascular Disease with Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome assoc. with Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/14 , 19 61 to 7/29 , 19 61 , that (I) (we) last saw the deceased alive on 7/29 , 19 61 , and that death occurred 2:10 am on the causes and on the date stated above.			
22a. SIGNATURE Enrique V. del Campo		22b. DATE SIGNED July 29/61	
22c. PHYSICIAN'S NAME (Type) Enrique V. del Campo		22d. ADDRESS Crownsville State Hospital Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE REOF 8-2-61	
23c. NAME OF CEMETERY OR CREMATORY Gardens of Eternal Hope		23d. LOCATION (City, town or county) (State) Finksburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Marshall W. Jones, Jr.		25a. REGISTERED BY REGISTRAR AUG 1 1961	
ADDRESS 3001-D Seabury Rd.		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

07552

2002

(M)

(1)

Chronic brain syndrome associated with arteriosclerosis and hypertensive disease

Chronic brain syndrome associated with arteriosclerosis and hypertensive disease

Chronic brain syndrome associated with arteriosclerosis and hypertensive disease

Chronic brain syndrome associated with arteriosclerosis and hypertensive disease

Chronic brain syndrome associated with arteriosclerosis and hypertensive disease

Chronic brain syndrome associated with arteriosclerosis and hypertensive disease

Chronic brain syndrome associated with arteriosclerosis and hypertensive disease

Chronic brain syndrome associated with arteriosclerosis and hypertensive disease

Chronic brain syndrome associated with arteriosclerosis and hypertensive disease

Chronic brain syndrome associated with arteriosclerosis and hypertensive disease

Chronic brain syndrome associated with arteriosclerosis and hypertensive disease

Chronic brain syndrome associated with arteriosclerosis and hypertensive disease

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7505

CERTIFICATE OF DEATH

Reg. Dist. No.

07496

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. LENGTH OF STAY IN 1b <u>14 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KIMBROUGH ARMY HOSPITAL</u>				d. STREET ADDRESS <u>Savage & Guilford Rd</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUAL</u> <u>-</u> <u>HEATON JR</u>				4. DATE OF DEATH Month Day Year <u>JULY</u> <u>10</u> <u>19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 July 1961</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Rual Heaton</u>				14. MOTHER'S MAIDEN NAME <u>Marilyn Heaton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mother-Savage & Guilford Rd Jessup, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10 July</u> , 19 <u>61</u> , to <u>10 July</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>10 July 61</u> , 19 <u>61</u> , and that death occurred at <u>5:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Kimbrough Army Hosp Ft Geo G. Meade, Md</u> DATE SIGNED <u>11 Jul 61</u>							
ACTUAL SIGNATURE <u>Sherman S. Robinson</u> PHYSICIAN'S NAME (Type) <u>SHERMAN S. ROBINSON, Capt., M.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-13-61</u>		<u>Beth Nat Cemetery</u>		<u>Beth City</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl B. Holberton</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 31 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7506 CERTIFICATE OF DEATH

07497

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 4 yrs. 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 535 Dolphin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Lucinda White Hines		4. DATE OF DEATH Month Day Year 7 17 19 61						
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1874	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days 7 17	IF UNDER 24 HRS. Hours Min. 19 61		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Albany, Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Anthony White		14. MOTHER'S MAIDEN NAME Charlotte ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Hospital Records Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Arteriosclerotic Cardiovascular Renal Disease (c) Disease DUE TO (e), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia; Fecal Impaction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----						
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----		
21. I certify that (I) (this hospital) attended the deceased from 7/13 , 19 57 , to 7/17 , 19 61 that (I) (we) last saw the deceased alive on 7/17 , 19 61 , and that death occurred at 7 A.M. from the causes and on the date stated above.							22a. SIGNATURE Hildegard Heard Reissman M.D. 22b. DATE SIGNED 7/17/61	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland		22e. ADDRESS Crownsville State Hospital, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3/22/61		23b. DATE THEREOF 3/22/61		23c. NAME OF CEMETERY OR CREMATORY Matthews		23d. LOCATION (City, town or county) (State) A A County Md		
24. FUNERAL DIRECTOR'S SIGNATURE A Halstead		24b. ADDRESS 918 Sun Hill Ave		25a. REG'D BY REGISTRAR DATE JUL 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline		

6250

2275

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
7507				CERTIFICATE OF DEATH				07498					
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN lb 1 1/2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severna Park d. STREET ADDRESS 207 Sycamore Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Cari Frances HOCK						4. DATE OF DEATH Month July Day 18 Year 1961							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1961		9. AGE (In years last birthday) yrs. 1 9		IF UNDER 1 YEAR IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Henry Francis Hock, Jr.						14. MOTHER'S MAIDEN NAME June Charlotte Harting							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } DUE TO Asphyxia Neonatorum PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (was present) attended the deceased from July 17, 1961 to July 18, 1961 , that (I) (was) last saw the deceased alive on July 18, 1961 , and that death occurred at 6:45 P.M. , from the causes and on the date stated above. 22a. SIGNATURE Clayton Norton M.D. 22c. PHYSICIAN'S NAME (Type) Dr. Clayton Norton 22b. DATE SIGNED 22d. ADDRESS Medical Building, Severna Park, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7/20/61 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery 23d. LOCATION (City, town or county) (State) Baltimore 8, Md. 24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave. 25a. REC'D BY REGISTRAR JUL 24 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas													

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7508

CERTIFICATE OF DEATH

Reg. Dist. No. 07499

1. PLACE OF DEATH a. COUNTY <u>ORUNDE L</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>10 yrs?</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Rt 2 Box 423</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 02X-1			
f. STREET ADDRESS <u>746 Washington Blvd</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>OTTO</u> Middle <u>A.</u> Last <u>HOFMANN</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/1900</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Flower Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>For Leaf</u>		11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward L. Hofmann</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Ukland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Mrs Anna V. Hofmann</u>		Address <u>746 Wash. Blvd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis.</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ca. of lung.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>July 6</u> , 19 <u>61</u> , to <u>July 7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>61</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmond I. Moushabek</u>		M.D. <u>21015 Ritchie Highway</u>		DATE SIGNED <u>7/7/61</u>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABEK</u>		<u>Glen Burnie, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/10/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>	22d. LOCATION (City, town, or county)	(State) <u>md</u>	23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan & Son</u>		
ADDRESS <u>Hallins St.</u>		24a. REC'D BY REGISTRAR <u>UL 10 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kline</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

07233

CERTIFICATE OF DEATH

1202

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7509

07500

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rivera Beach</u> c. LENGTH OF STAY IN 1b <u>years?</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>243 Glenwood Rd.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rivera Beach</u> d. STREET ADDRESS <u>243 Glenwood Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Keith</u> <u>Hummer</u>		4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/2/1891</u>		9. AGE (in years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Robert D. Emerst</u>				14. MOTHER'S MARRIED NAME <u>Elizabeth Schwaker</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes give year or dates of service) <u>218-22407</u>				16. SOCIAL SECURITY NO. <u>218-22407</u>				17. INFORMANT <u>Mr Elmer Emerst</u> Address <u>826 Cedar St. Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (e), stating the underlying cause last. DUE TO (c) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Hour e.m. <u></u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>				20f. (City or town) (County) (State) <u></u>							
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>61</u> , to <u>July 28</u> , 19 <u>61</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>July 28</u> , 19 <u>61</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.																			
22a. SIGNATURE <u>J. Brady Smith</u> M.D.												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/29/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>												22d. ADDRESS <u>RIVERA BEACH, PASADENA, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8/1/61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Woodlawn Md.</u>							
24. GENERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u>												25. REC'D BY REGISTRAR <u>Aug 1 61</u>		25b. REGISTRAR'S SIGNATURE <u>C. L. H. H.</u>					

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "MAY 1911" and "MAY 1912" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7510

07501

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calverley Forest</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 54 W Luther Pkwy.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>54 W Luther Pkwy.</u>		d. STREET ADDRESS <u>100 Calverley Forest</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Shelley D. Hutchinson</u>		4. DATE OF DEATH Month Day Year <u>7-13-61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 19-1864</u>
9. AGE (In years last birthday) <u>96</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cypselanti, Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Stephen Hutchinson</u>		14. MOTHER'S MAIDEN NAME <u>Zoretta</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> 19 to <u>1961</u> 19, that (I) (we) last saw the deceased alive on <u>7-13-61</u> 19, and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Holm</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Holm</u>		22d. ADDRESS <u>Severna Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE THEREOF <u>7-18-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Cypselanti, Mich.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>McBully, L. J.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 17 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

07501

CERTIFICATE OF DEATH

2016

(M)

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CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7511

CERTIFICATE OF DEATH

07502

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Ma</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>10</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Homewood Convalescent Home</i>		d. STREET ADDRESS <i>15 Annapolis St</i>	
3. NAME OF DECEASED (Type or print) First <i>Minnie</i> Middle <i>Marshall</i> Last <i>Jackson</i>		4. DATE OF DEATH Month <i>7</i> - Day <i>8</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 22-1875</i>
9. AGE (In years last birthday) <i>85</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13. FATHER'S NAME <i>Jacob Gilbert</i>		14. BIRTHPLACE (State or foreign country) <i>Pa.</i>	
15. MOTHER'S MAIDEN NAME <i>Elizabeth Small</i>		16. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		18. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>577-07-3848</i>	
19. INFORMANT <i>Robert L. Jones</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Or Myocarditis with Acute Cardiac failure</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Broncho pneumonia</i> (c) <i>Arterial Hypertension General Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>30 days</i> <i>Several yrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3-23</i> 1961 to <i>July 8th</i> 1961, that (I) (we) last saw the deceased alive on <i>7-8</i> 1961, and that death occurred at <i>2:55</i> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <i>J. Oliver Purvis</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>J. Oliver Purvis</i>		22d. ADDRESS <i>Annapolis Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7-11-1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Gettysburg Pa</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		25a. REC'D BY REGISTRAR <i>EUL 12 '61</i>	
ADDRESS <i>Annapolis Md</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7512

CERTIFICATE OF DEATH

07503

Item 8 Film G291 7/26/61 lwk

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN b 11 months		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Plaza Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH July 16, 19 61		5. SEX Female		6. COLOR OR RACE Negro	
3. NAME OF DECEASED (Type or print) Anna Jones		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 5 1895 7-17-1891		9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic worker		10b. KIND OF BUSINESS OR INDUSTRY Domestic service		11. BIRTHPLACE (County & State, or foreign country) Northumberland Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Levi Campbell	
14. MOTHER'S MAIDEN NAME Charlotte Washington		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-26-8253		17. INFORMANT Malissa Jones		Address 1007 N. Stricker St. Balto. 17	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio vascular disease with aortic stenosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) 422.1 (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH ? yrs.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 19		(County) 19		(State) 19		21. I certify that (I) (this hospital) attended the deceased from August 21, 1960 to July 16, 1961 that (I) (we) last saw the deceased alive on July 8, 1961 , and that death occurred at 7:15 P.M. from the causes and on the date stated above.		22a. SIGNATURE James M. Pair M.D.	
22b. DATE SIGNED July 17, 1961		22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D.		22d. ADDRESS 400 N. Carrollton Avenue Balto. 23, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 19-61 Church Cemetery Lottsburg Va		23b. DATE THEREOF July 19-61	
23c. NAME OF CEMETERY OR CREMATORY Church Cemetery		23d. LOCATION (City, town or county) Lottsburg Va		23e. REC'D BY REGISTRAR V. Brooks Ruggold		23f. REGISTRAR'S SIGNATURE 1463 N. Carey St		23g. DATE JUL 19 61	

07503

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7513

CERTIFICATE OF DEATH

07504

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>F.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOMEWOOD NURSING HOME</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Clifton</u> Middle <u>Keesaer</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-1866</u>
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LUMBERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PLANT SUPERVISOR</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>"UNK"</u>		14. MOTHER'S MAIDEN NAME <u>"UNK"</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>233-20-0391</u>	
17. INFORMANT <u>Mrs. Harry R. King</u> Address <u># 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1866</u> to <u>30 July 1961</u> , that (I) (we) last saw the deceased alive on <u>30 July 1961</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u> M.D.		22b. DATE <u>JULY 31 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		22d. ADDRESS <u>73 FRANKLIN ST. ANNAPOLIS MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-2-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>VALLEY VIEW CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>HARRISBURG W. VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 2 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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(2)

17504

CENTRE OF DEATH

17513

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1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>				c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manor Rd Carrollton Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Manor Rd.</u>				d. STREET ADDRESS <u>Severna Park Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Max John Kehm.</u> First Middle Last				4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1894</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mathias Kehm.</u>				14. MOTHER'S MAIDEN NAME <u>Anna Seifert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-30-6701</u>		17. INFORMANT <u>Mrs Katherine Kehm</u> Address <u>1431 Decatur St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u> DUE TO (b) <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>163X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>163X</u> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>1961</u> , that (I) (we) last saw the deceased alive on <u>7-3-61</u> 19 <u>61</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert R. Hahn</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>				22d. ADDRESS <u>Severna Park Md</u>			
23a. BURIAL, CREMATION, REMOVALS (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-6-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Stevens</u> ADDRESS <u>Funeral Home, Inc. 1501 E. FORT AVE.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hahn</u>	

(M)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7515

CERTIFICATE OF DEATH

Reg. Dist. No. 07506

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 11 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 Whip Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herbert Middle Liston Last KELSO		4. DATE OF DEATH Month July Day 10 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Octg 15, 1911
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 49 Days 10 Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance broker		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (State or foreign country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? Yes U.S.A	
13. FATHER'S NAME Herbert Sylvester Kelso (dec)		14. MOTHER'S MAIDEN NAME Sythia Jones (dec)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 498-16-3536	
17. INFORMANT Mrs. Elizabeth Ke so (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO 411 X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Subacute bacterial endocarditis DUE TO 7 wks. (c) Rheumatic valvular disease (aortic regurg) 33 yrs		INTERVAL BETWEEN ONSET AND DEATH 7 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 55 to July 10 , 19 61 that I last saw the deceased alive on July 8 , 19 61 , and that death occurred at 9:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 425 S. Ritchie Hwy. DATE SIGNED 10 July 1961		ACTUAL SIGNATURE H-F. Manuzak M.D.	
PHYSICIAN'S NAME (Type) H.F. Manuzak		Glen Burnie, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 13th July 1961	
22c. NAME OF CEMETERY OR CREMATORY London Park		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton		ADDRESS Glen Burnie, Md.	
24a. REC'D BY REGISTRAR DATE JUL 14 '61		24b. REGISTRAR'S SIGNATURE Arthur S. House	

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		TIME OF BIRTH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		MEDICAL ATTENDANT [Illegible]	
CORONER [Illegible]		BURIAL PLACE [Illegible]		DATE OF BURIAL [Illegible]	
SIGNATURE OF CORONER [Illegible]		SIGNATURE OF MEDICAL ATTENDANT [Illegible]		SIGNATURE OF DECEASED [Illegible]	
SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF WITNESS [Illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07507

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stanley Middle KITURAKIS Last Box-7		4. DATE OF DEATH Month July Day 10 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1897
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobiles	
11. BIRTHPLACE (County & State, or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Deceased		14. MOTHER'S MAIDEN NAME Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W.W.I 217-24-9373	
17. INFORMANT RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO Pulmonary and pleural metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Carcinoma of tongue			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Lymphatic Leukemia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from July 1, 1961 to July 9, 1961 , that (I) (we) last saw the deceased alive on July 9, 1961 , and that death occurred at 1:55 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman M.D.		22b. DATE SIGNED 1:55 A.M.	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman		22d. ADDRESS 100 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/5/61	
23c. NAME OF CEMETERY OR CREMATORY Balto National		23d. LOCATION (City, town or county) (State) Fredrick MD Md	
24. FUNERAL DIRECTOR'S SIGNATURE Charles W. Jackson		25a. REC'D BY REGISTRAR DATE JUL 13 '61	
ADDRESS 637 Wash Blvd		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7517
CERTIFICATE OF DEATH

07508

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <u>M.D.</u> b. COUNTY <u>A.A. Co.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>JESSUPS</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>JESSUPS</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>JESSUPS RD.</u>				d. STREET ADDRESS <u>1 JESSUPS RD.</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK</u> <u>M.</u> <u>KNIGHT</u>				4. DATE OF DEATH Month Day Year <u>JULY</u> <u>21</u> <u>1961</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 25, 1905</u>			
9. AGE (in years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MGR.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BICUIT CO.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>M.D.</u>			
12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME <u>FRANK L. KNIGHT</u>				14. MOTHER'S MAIDEN NAME <u>MARY J. NORTON</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardio-Vas. Disease</u> (c) <u>Diabetes</u> DUE TO cause last. (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u> <u>2 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 21, 1961</u> to <u>July 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 21, 1961</u> , and that death occurred at <u>5:59 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Frank E. Shipley, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DAY SIGNED <u>7/23/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D.</u>				22d. ADDRESS <u>Savage, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-24-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE CEM.</u>		23d. LOCATION (City, town or county) (State) <u>ELBRIDGE MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>July - Caravang B. H. - Catonsville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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Hoffman's

Richard

July 21 1961

July 21 61

Frank E. Stilleman
June 21 1961

June 21 1961

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7518

CERTIFICATE OF DEATH

07509

1. PLACE OF DEATH a. COUNTY <u>Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Andover & Maryland ave., P.O. Box 230</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Linthicum Heights</u> d. STREET ADDRESS <u>Maryland Ave., Near Andover Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph (Joe) Knox</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/13/1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Alabama</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-16-4105</u>	
17. INFORMANT Address <u>Julia Knox Maryland Ave. & Andover Rd.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AC CEREBRAL VASCULAR ACCIDENT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DIS</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John S. Branton Jr.</u> M.D.		22b. DATE SIGNED <u>7/6/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. BRANTON JR.</u>		22d. ADDRESS <u>922 S. SHARP.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/6/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Rice 661 W. Barre St.</u>		25a. REC'D BY REGISTRAR <u>AUG 12 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Amund, Amund Heights, P.O. Box 100, Amund Heights, Alaska

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7519

CERTIFICATE OF DEATH

07510

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lombardy Beach</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KNOXWOOD NURSING</u>				d. STREET ADDRESS <u>ROUTE 1 BOX 212 NABBS CREEK</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>M</u> Last <u>KUHL</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 17, 1901</u>	
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE BOWERS</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH WEINBERG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT Address <u>Route 1 Box 212 NABBS CREEK RD.</u> <u>ELIZABETH NIEMEYER</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac decompensation</u> 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Cerebrovascular accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 years</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Oct. 20, 1952</u> to <u>July 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>July 3, 1961</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>R.M. McLaughlin</u>				22b. PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>		22c. ADDRESS <u>3708 Mountain Rd. Pasadena, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-10-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schaub</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 10 61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Howard</u>	

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CENTRAL OF DEATH

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Arthur S. Kraus

07511

7532 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

(M)

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[Faint text in the lower-middle section, possibly a declaration or additional notes.]

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FOR STATE
HEALTH DEPT. M

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7521 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07512

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22	
c. LENGTH OF STAY IN b 3 hours		d. STREET ADDRESS 207 Parkwood Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Martin Co. Office Building		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Herbert Larrimore		4. DATE OF DEATH 7/25/61 19	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8/2/16	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 44 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe fitter		10b. KIND OF BUSINESS OR INDUSTRY Rockhall, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William R. Larrimore		14. MOTHER'S MAIDEN NAME Barbara Margaret Frost	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes, World War # 2		16. SOCIAL SECURITY NO. 213-07-7874	
17. INFORMANT Mrs. Lilian M. Larrimore		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/25/61	
Address (Street, city, town, or county) Glen Burnie, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-28-61	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or country) (State) Catonsville, Md.	
23. FUNERAL DIRECTOR Ullrich Funeral Home, Dundalk, Md.		24. REC'D BY REGISTRAR DA JUL 27 1961	
24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

17512

17512



Washington County

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7522

07513

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 10 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 136 Riverview Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George First Middle Last R. LOFTUS		4. DATE OF DEATH Month Day Year July 21 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1892
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAREHOUSE SUPT.		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE W LOFTUS		14. MOTHER'S MAIDEN NAME CLARA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. World War I	
17. INFORMANT ELSIE M. LOFTUS		Address (2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery Disease DUE TO (c) 11 yrs.		INTERVAL BETWEEN ONSET AND DEATH DOA	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his name) attended the deceased from 1954 , 19 7-21-61 , that (I) (his name) saw the deceased alive on 7-21-61 , 19 7-21-61 , and that death occurred at 4:40 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Frank M. Shiple M.D. FRANK M-SHIPLEY		22b. DATE SIGNED 7-24-61	
22c. PHYSICIAN'S NAME (Type or print)		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 7-25-1961	
23c. NAME OF CEMETERY OR CREMATORY Annapolis National		23d. LOCATION (City, town or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John W. Taylor Sons		25a. REC'D BY REGISTRAR JUL 26 '61	
ADDRESS Annapolis Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

22



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7523

CERTIFICATE OF DEATH

07514

Item 9 Film G290 7/17/61 iwk

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY in lb 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Severna Park d. STREET ADDRESS Rt-2, Box-583 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lois M. LONG		4. DATE OF DEATH Month July Day 11 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1915
9. AGE (In years last birthday) 45 16/18		10. IF UNDER 1 YEAR Months 45 Days 16 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher		10b. KIND OF BUSINESS OR INDUSTRY Schools	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Merton Long		14. MOTHER'S MAIDEN NAME Maude Yeigh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. Janet A. Long, Mifflintown, Pa.	
17. INFORMANT Janet A. Long, Mifflintown, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Fibrosarcoma of Ovary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 11, 1961 to July 11, 1961 , that (I) (we) last saw the deceased alive on 7-11-1961 , and that death occurred at 3:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE James R. Martin		22b. DATE SIGNED 7-11-61	
22c. PHYSICIAN'S NAME (Type) JAMES R. MARTIN		22d. ADDRESS 6 SHAW ST, ANNAPOLIS, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/13/61	
23c. NAME OF CEMETERY OR CREMATORY Old Church Hill Cemetery		23d. LOCATION (City, town or county) (State) Port Royal, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		25a. REC'D BY REGISTRAR DATE JUL 14 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

17513

17513

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death of the decedent. The law also requires that the death certificate be retained by the hospital or attending physician for 10 years. The law also requires that the death certificate be retained by the hospital or attending physician for 10 years. The law also requires that the death certificate be retained by the hospital or attending physician for 10 years.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7524

07515

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>1 yr. 1 mo 1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>204 Wintertane</u>															
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>W.</u> Last <u>Lowman</u>				4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1961</u>															
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/28/1870</u>		9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coachman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Livery</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>William Burkett</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Lowman</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Medical Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure and Uremia</u> DUE TO (b) <u>CVA</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u>General Arteriosclerosis + Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with General arteriosclerosis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>									
21. I certify that (I) (this hospital) attended the deceased from <u>6/15/61</u> to <u>7/29/61</u> , that (I) (we) last saw the deceased alive on <u>9/28/61</u> , and that death occurred at <u>9:00 p.m.</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>Robert M. Henry</u>												22b. DATE SIGNED <u>8/1/61</u>							
22c. PHYSICIAN'S NAME (Type) <u>Robert M. Henry</u>												22d. ADDRESS <u>Crownsville State Hospital</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-1-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>White Rock</u>		23d. LOCATION (City, town, or county) <u>Crownsville, Md.</u>		(State) <u>Md.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth A. Haight</u>												25a. RECEIVED BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>					

MEDICAL CERTIFICATION

M

1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be noted in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

18-21 Film 293 8-21-61											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7525 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07516											
Item 7 Film 0292 8/9/61 iwk											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Philadelphia</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oyster Harbor</u>				c. LENGTH OF STAY IN lb. <u>Unspecified</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>5834 Delancey Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MALCOLM ARTHUR MARTIN</u>				4. DATE OF DEATH Month Day Year <u>July 31, 19 61</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-7-1939</u>		9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Pennsylvania U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ronald S. Martin</u>				14. MOTHER'S MAIDEN NAME <u>Edith Gardner</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>Ronald S. Martin</u>				17. INFORMANT Address <u>Phila. 43-PA</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. } DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Acute alcoholism</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found drowned</u>							
20c. TIME OF INJURY Month, Day, Year <u>Found 1:04 p.m. 7/30/19 61</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Harbor</u>		20f. (City or town) <u>Anne Arundel</u> (County) <u>Md.</u> (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Peter W. Rieckert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>7/31/61</u>			
EXAMINER'S NAME (Type) <u>Peter W. Rieckert, M.D.</u>				M.D. ASSISTANT MEDICAL EXAMINER <u>Associate Pathologist</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7-5-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Golling Green</u>		22d. LOCATION (City, town, or county) <u>Phila. Pa.</u> (State)			
23. FUNERAL DIRECTOR <u>William Reese, 47-Anna. Md.</u>				ADDRESS				24a. REC'D BY REGISTRAR <u>AUG 7 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

2328

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7526
CERTIFICATE OF DEATH

07517

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN lb 10 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 201 S. Southwood Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen First MARX Middle July Last 20 Date of Death 1961		4. DATE OF DEATH Month July Day 20 Year 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 3, 1923	
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Maxwell Ochs		14. MOTHER'S MAIDEN NAME Ray Busky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mr. Marcus S. Marx		Address Husband same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding into cerebral metastases 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic adenocarcinoma of breast DUE TO (c) C. g.		INTERVAL BETWEEN ONSET AND DEATH 9 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (deceased) attended the deceased from 7-20-61 19____, to July 20, 1961 , that (I) (was) last saw the deceased alive on July 20, 1961 , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley M.D.		22b. DATE SIGNED 7/21/61	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 21, 1961	
23c. NAME OF CEMETERY OR CREMATORY Kneseth Israel		23d. LOCATION (City, town or county) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.		25a. REC'D BY REGISTRAR AJUL 24 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



Государственный архив Республики Беларусь

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07518

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 102 College Creek Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle MATTHEWS Last MATTHEWS		4. DATE OF DEATH Month July Day 17 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1905
9. AGE (In years last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Matthews		14. MOTHER'S MAIDEN NAME Phebe Stevens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-14-0687	
17. INFORMANT Olivia Matthews		Address 102 College Creek Terrace	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) aortic insufficiency DUE TO (c) neurosyphilis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 16th		20f. (City or town) (County) (State)	
21. I certify that (I) Dr. Edith Rodler attended the deceased from June 21, 1961 to July 16, 1961 , that (I) 300 last saw the deceased alive on July 16, 1961 , and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE Edith Rodler		22b. DATE SIGNED 3:30 A.M.	
22c. PHYSICIAN'S NAME (Type) Dr. Edith Rodler		22d. ADDRESS 45 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 7-22-61		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Broadneck		23d. LOCATION (City, town or county) (State) St. Mary's Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Keesett		25. REC'D BY REGISTRAR Anna M.D.	
25a. DATE JUL 26 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kress	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MD
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7528
CERTIFICATE OF DEATH
07519

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL CO MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RIVIERA BEACH c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 164 DALE RD.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RASADENA - RIVIERA BEACH d. STREET ADDRESS 164 DALE RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN WILLIAM McGUIRE First Middle Last		4. DATE OF DEATH JULY 17 1961 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 25, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WORKER-SANITATION		10b. KIND OF BUSINESS OR INDUSTRY BALTO. CO.	9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JOHN J. Mc GUIRE		14. MOTHER'S MAIDEN NAME ELIZABETH A. OHLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-01-7825 HA	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH INIT. 5 YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JAN 1961 , to JULY 17, 1961 , that (I) (we) last saw the deceased alive on JULY 10, 1961 , and that death occurred at 8 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE J. Brady Smith M.D.		22b. DATE SIGNED JULY 17, 1961	
22c. PHYSICIAN'S NAME (Type) J. BRADY SMITH		22d. ADDRESS RIVIERA BEACH, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/20/61	23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CATHOLIC Cem.	23d. LOCATION (City, town or county) (State) LONG GREEN MD.
24. FUNERAL DIRECTOR'S SIGNATURE John Bruno Sons ADDRESS Towson MD		25a. REC'D BY REGISTRAR JUL 21 '61	25b. REGISTRAR'S SIGNATURE C. L. & Thoma

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7529

CERTIFICATE OF DEATH

Reg. Dist. No. 07520

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>O.</u> Last <u>McKenzie</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/1867</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tobacco Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>George McKenzie</u>		Address <u>Lothian, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 5</u> , 19 <u>61</u> , to <u>July 17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>61</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Shadyside, Md.</u>		DATE SIGNED <u>7/18/61</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/21/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of Sorrows Catholic Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Owensville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home-Up'r Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u>JUL 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7530

CERTIFICATE OF DEATH

Reg. Dist. No. 07521

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Crownsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Knowlwood Nursing Home</u>				d. STREET ADDRESS <u>none</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>H</u> Last <u>MEADE</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>19 61</u>			
5. SEX <u>Felame</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7, 1961</u>	
9. AGE (In years lost birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Edward S. Schad- same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Delat. Pulm Pneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Generalized Arteriosclerosis</u> <u>Radio Vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>April</u> 19 <u>61</u> to <u>July 14</u> 19 <u>61</u> , that I last saw the deceased alive on <u>June 30</u> 19 <u>61</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>609 Bodentown Rd Odenton, Maryland</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Felam F. Grunberg</u>							
PHYSICIAN'S NAME (Type) <u>Felam F. Grunberg MD</u>				<u>Odenton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 17, 61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Millersville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 18 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

1930

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>BIRTH <i>Jan 15 1885</i></p>		<p>DEATH <i>Dec 10 1930</i></p>		<p>PLACE OF BIRTH <i>New York City</i></p>		<p>PLACE OF DEATH <i>New York City</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>		<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Teacher</i></p>	
<p>RESIDENCE <i>123 Main St, New York City</i></p>		<p>DATE OF INTERMENT <i>Dec 12 1930</i></p>		<p>PLACE OF INTERMENT <i>Cemetery</i></p>		<p>NAME OF MINISTER <i>Rev. John Smith</i></p>	
<p>SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>SIGNATURE OF WITNESSES <i>John Smith, Mary Doe</i></p>		<p>SIGNATURE OF CLERK <i>John Doe</i></p>		<p>SIGNATURE OF JUDGE <i>John Doe</i></p>	

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FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7531 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07522											
1. PLACE OF DEATH a. COUNTY Anne Arundel						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 26						c. LENGTH OF STAY IN 1b X Baltimore 26					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wieland Cove, Carvel Beach						d. STREET ADDRESS 458 Carvel Beach Rd.					
3. NAME OF DECEASED (Type or print) JERRY Jeery Lee Moon						4. DATE OF DEATH Month Day Year July 4th. 19 61					
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/8/48		9. AGE (In years last birthday) 12 yrs.		IF UNDER 1 YEAR Months Days 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None .Pupil				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.				11. BIRTHPLACE (State or foreign country) Baltimore, Md.			
12. CITIZEN OF WHAT COUNTRY? USA						13. FATHER'S NAME Gordon Leroy Moon					
14. MOTHER'S MAIDEN NAME Violet Willetta Rollins						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					
16. SOCIAL SECURITY NO. None						17. INFORMANT Parents					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found drowned (Swimming)					
20c. TIME OF INJURY Hour a.m. 11:30		Month, Day, Year 7/4 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Water		20f. (City or town) Anne Arundel Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/5/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) B						22b. DATE THEREOF 7-7-61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or country) (State) Brooklyn 25 MD	
23. FUNERAL DIRECTOR Mc Cully Funeral Hns.						ADDRESS 130 E. Fort Ave		24a. REC'D BY REGISTRAR JUL 7 '61		24b. REGISTRAR'S SIGNATURE William S. Evans	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7532

07523

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>1 Mo. 10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2824 Baker St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Henry Moss</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		4. DATE OF DEATH <u>July 29 1961</u> 9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. <u> </u> 13. FATHER'S NAME <u>Allen Moss</u> 14. MOTHER'S MAIDEN NAME <u>Eva E. Thompson</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>8995</u> 17. INFORMANT <u>Medical Record</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Heart Failure</u> 304X DUE TO <u>CVA</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above. 22a. SIGNATURE <u>Charles Ward</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Charles Ward</u> 22d. ADDRESS <u>Crownsville State Hosp. Md.</u> 22b. DATE SIGNED <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8/2/61</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>E.D. Wilson</u> ADDRESS <u>1000 Brawthey Ave</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL Cem.</u> 23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>Md.</u> 25a. REC'D BY REGISTRAR <u>AUG 3 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death of the decedent. The law requires that the death certificate be executed within 24 hours after the death of the decedent. The law requires that the death certificate be executed within 24 hours after the death of the decedent.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7533
CERTIFICATE OF DEATH
07524

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel Gen</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u> d. STREET ADDRESS <u>245 Glenwood Road.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank U. U</u> First Middle Last		4. DATE OF DEATH <u>7-15-1961</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2/07</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemical Eng.</u>		12. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>	
13. FATHER'S NAME <u>Benjamin C Neat</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Esther M. Neat 245 Glenwood Road Riviera Beach</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Acute Coronary Occlusion</u> <u>420.1</u> DUE TO <u>& myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Coronary Artery Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Chronic Cholecystitis & Cholelithiasis</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/12/61</u> to <u>7/15/61</u> that (I) (we) last saw the deceased alive on <u>7/13/61</u> and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>J. Fred Hawkins Jr.</u> M.D. 22b. DATE SIGNED <u>7/15/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Fred Hawkins Jr.</u>		22d. ADDRESS <u>98 Cathedral St. Annapolis</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7.19.61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City, town or county) (State) <u>A.A. Co Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>McCully</u>		25. REC'D BY REGISTRAR <u>JUL 18 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>130 El Fort Ave Balto 30 Md.</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7534

07525

1. PLACE OF DEATH a. COUNTY <u>An. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>33 Hicks Ave.</u>		d. STREET ADDRESS <u>33 Hicks Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Sidney</u> First <u>Owens</u> Middle <u>Owens</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-12-1919</u>
9. AGE (In years lost birthday) <u>41</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Camilla Pinkney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-16-0417</u>	
17. INFORMANT <u>Margaret Johnson</u> Address <u>46 parole st.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>162.1</u> DUE TO <u>bronchogenic carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>H was</u> DUE TO (c) <u>H was</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1961</u> to <u>7-16-61</u> , that (I) (we) lost the deceased alive on <u>7-16-61</u> , and that death occurred at <u>7-16-61</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>PAIS T. ALLEY</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>7-17-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAIS T. ALLEY</u>		22d. ADDRESS <u>61 Calhoun</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-19-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>Annapolis</u>		25a. REC'D BY REGISTRAR <u>Arthur E. Hume</u> DATE <u>JUL 19 1961</u>	
		25b. REGISTRAR'S SIGNATURE	

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CERTIFICATE OF DEATH

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[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7535

CERTIFICATE OF DEATH

Reg. Dist. No.

07526

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Friendship MARYLAND b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendship		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendship	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bessie Middle E. Last Paddy		4. DATE OF DEATH Month July Day 4 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1879
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Birkhead		14. MOTHER'S MAIDEN NAME Janie Fowler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT Edna Paddy		Address Friendship, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/12/61 , 19 61 , to 7/4/61 , 19 61 , that I last saw the deceased alive on 7/4/61 , 19 61 , and that death occurred at 9:30A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Emily H. Wilson M.D.		ADDRESS (Street, city or town, state) Lothian DATE SIGNED 7-5-61	
PHYSICIAN'S NAME (Type) Emily H. Wilson		Lothian A.A. Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 6, 1961	22c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery	22d. LOCATION (City, town, or county) (State) Friendship, A.A. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home		ADDRESS Quinn's Mt	
24a. REC'D BY REGISTRAR DATE JUL 10 '61		24b. REGISTRAR'S SIGNATURE Arthur J. H.	

CERTIFICATE OF DEATH

0738

235

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12/5/29		6. BIRTH PLACE Jackson, Mississippi	
7. OCCUPATION Minister		8. MARITAL STATUS Single		9. EDUCATION High School	
10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. PLACE OF DEATH Home	
13. DATE OF DEATH 4/4/68		14. TIME OF DEATH 10:00 AM		15. SIGNATURE OF PHYSICIAN [Signature]	
16. SIGNATURE OF REGISTRAR [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF DECEASED [Signature]	
19. SIGNATURE OF NEXT OF KIN [Signature]		20. SIGNATURE OF CLERK [Signature]		21. SIGNATURE OF CHURCH CLERK [Signature]	
22. SIGNATURE OF MINISTER [Signature]		23. SIGNATURE OF BURIAL CLERK [Signature]		24. SIGNATURE OF CREMATION CLERK [Signature]	
25. SIGNATURE OF INTERMENT CLERK [Signature]		26. SIGNATURE OF REINTERMENT CLERK [Signature]		27. SIGNATURE OF REINTERMENT CLERK [Signature]	
28. SIGNATURE OF REINTERMENT CLERK [Signature]		29. SIGNATURE OF REINTERMENT CLERK [Signature]		30. SIGNATURE OF REINTERMENT CLERK [Signature]	
31. SIGNATURE OF REINTERMENT CLERK [Signature]		32. SIGNATURE OF REINTERMENT CLERK [Signature]		33. SIGNATURE OF REINTERMENT CLERK [Signature]	
34. SIGNATURE OF REINTERMENT CLERK [Signature]		35. SIGNATURE OF REINTERMENT CLERK [Signature]		36. SIGNATURE OF REINTERMENT CLERK [Signature]	
37. SIGNATURE OF REINTERMENT CLERK [Signature]		38. SIGNATURE OF REINTERMENT CLERK [Signature]		39. SIGNATURE OF REINTERMENT CLERK [Signature]	
40. SIGNATURE OF REINTERMENT CLERK [Signature]		41. SIGNATURE OF REINTERMENT CLERK [Signature]		42. SIGNATURE OF REINTERMENT CLERK [Signature]	
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49. SIGNATURE OF REINTERMENT CLERK [Signature]		50. SIGNATURE OF REINTERMENT CLERK [Signature]		51. SIGNATURE OF REINTERMENT CLERK [Signature]	
52. SIGNATURE OF REINTERMENT CLERK [Signature]		53. SIGNATURE OF REINTERMENT CLERK [Signature]		54. SIGNATURE OF REINTERMENT CLERK [Signature]	
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58. SIGNATURE OF REINTERMENT CLERK [Signature]		59. SIGNATURE OF REINTERMENT CLERK [Signature]		60. SIGNATURE OF REINTERMENT CLERK [Signature]	
61. SIGNATURE OF REINTERMENT CLERK [Signature]		62. SIGNATURE OF REINTERMENT CLERK [Signature]		63. SIGNATURE OF REINTERMENT CLERK [Signature]	
64. SIGNATURE OF REINTERMENT CLERK [Signature]		65. SIGNATURE OF REINTERMENT CLERK [Signature]		66. SIGNATURE OF REINTERMENT CLERK [Signature]	
67. SIGNATURE OF REINTERMENT CLERK [Signature]		68. SIGNATURE OF REINTERMENT CLERK [Signature]		69. SIGNATURE OF REINTERMENT CLERK [Signature]	
70. SIGNATURE OF REINTERMENT CLERK [Signature]		71. SIGNATURE OF REINTERMENT CLERK [Signature]		72. SIGNATURE OF REINTERMENT CLERK [Signature]	
73. SIGNATURE OF REINTERMENT CLERK [Signature]		74. SIGNATURE OF REINTERMENT CLERK [Signature]		75. SIGNATURE OF REINTERMENT CLERK [Signature]	
76. SIGNATURE OF REINTERMENT CLERK [Signature]		77. SIGNATURE OF REINTERMENT CLERK [Signature]		78. SIGNATURE OF REINTERMENT CLERK [Signature]	
79. SIGNATURE OF REINTERMENT CLERK [Signature]		80. SIGNATURE OF REINTERMENT CLERK [Signature]		81. SIGNATURE OF REINTERMENT CLERK [Signature]	
82. SIGNATURE OF REINTERMENT CLERK [Signature]		83. SIGNATURE OF REINTERMENT CLERK [Signature]		84. SIGNATURE OF REINTERMENT CLERK [Signature]	
85. SIGNATURE OF REINTERMENT CLERK [Signature]		86. SIGNATURE OF REINTERMENT CLERK [Signature]		87. SIGNATURE OF REINTERMENT CLERK [Signature]	
88. SIGNATURE OF REINTERMENT CLERK [Signature]		89. SIGNATURE OF REINTERMENT CLERK [Signature]		90. SIGNATURE OF REINTERMENT CLERK [Signature]	
91. SIGNATURE OF REINTERMENT CLERK [Signature]		92. SIGNATURE OF REINTERMENT CLERK [Signature]		93. SIGNATURE OF REINTERMENT CLERK [Signature]	
94. SIGNATURE OF REINTERMENT CLERK [Signature]		95. SIGNATURE OF REINTERMENT CLERK [Signature]		96. SIGNATURE OF REINTERMENT CLERK [Signature]	
97. SIGNATURE OF REINTERMENT CLERK [Signature]		98. SIGNATURE OF REINTERMENT CLERK [Signature]		99. SIGNATURE OF REINTERMENT CLERK [Signature]	
100. SIGNATURE OF REINTERMENT CLERK [Signature]		101. SIGNATURE OF REINTERMENT CLERK [Signature]		102. SIGNATURE OF REINTERMENT CLERK [Signature]	

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THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD. IT IS NOT VALID FOR ANY OTHER PURPOSES.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7536

07527

1. PLACE OF DEATH e. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 1877 Highland Dr. Edgewater, Md.	
3. NAME OF DECEASED (Type or print) First John Middle PETRELLO Last PETRELLO		4. DATE OF DEATH Month July Day 20 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1904
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 56 Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resturant Owner		10b. KIND OF BUSINESS OR INDUSTRY Food	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Dominic Petrello		14. MOTHER'S MAIDEN NAME Elbina Scagnelli	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mildred H Petrello Same As #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Terminal pneumonia 163X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) Carcinoma of lung & multiple metastasis to bone & skin DUE TO (c) metastasis to bone & skin		INTERVAL BETWEEN ONSET AND DEATH one week 9 months or more	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from May 10, 1961 to July 19, 1961 , that (I) (we) last saw the deceased alive on July 19, 1961 , and that death occurred at 7:50 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Willard F. Smith MD M.D.		22b. DATE SIGNED 7:50 A.M.	
22c. PHYSICIAN'S NAME (Type) Dr. Willard Smith		22d. ADDRESS Shadyside, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/24/61	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) (State) Bladensburg Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co 517 11th St. S.E. Wash DC		25a. REC'D BY REGISTRAR DATE JUL 24 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO VITAL RECORDS: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7537

CERTIFICATE OF DEATH

07528

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN b. 10 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 3 Silopanna Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) Lula POSEY		4. DATE OF DEATH July 22 19 61		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1894		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 22 Days 19		IF UNDER 24 HRS. Hours 61 Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY own home				11. BIRTHPLACE (County & State, or foreign country) Alabama				12. CITIZEN OF WHAT COUNTRY? U.S.											
13. FATHER'S NAME Bruce H. Kelly						14. MOTHER'S MAIDEN NAME Selma Raden																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. husband # 411 01 7625						17. INFORMANT John Ellis Posey husband same as # 2											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage due to hypertension 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) arteriosclerosis (c) hypertension INTERVAL BETWEEN ONSET AND DEATH 4 days yes.												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (DECEASED) attended the deceased from July 18, 19 61 to July 22, 19 61, that (I) (DECEASED) saw the deceased alive on July 22, 19 61, and that death occurred at M, from the causes and on the date stated above.																							
22a. SIGNATURE Frank M. Shipley 22c. PHYSICIAN'S NAME (Type) FRANK M. SHIPLEY												22b. DATE SIGNED 1-25-61 22d. ADDRESS 121 Cathedral St., Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF July 25, 61						23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery						23d. LOCATION (City, town or county) (State) Annapolis, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home												25a. REC'D BY REGISTRAR JUL 27 '61						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

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ANNAPOLIS, MD.

July 27, 61

ANNAPOLIS, MD.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7538

07529

1. PLACE OF DEATH a. COUNTY <u>a. a.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>a. a.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>183 Gloucester St</u>				d. STREET ADDRESS <u>183 Gloucester St</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Anne Redmond</u>				4. DATE OF DEATH Month Day Year <u>7-10-1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 15-1890</u>			
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>St Marys Co Md</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME <u>William Basil</u>				14. MOTHER'S MAIDEN NAME <u>Althea Watson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs George K. Weber</u> (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> DUE TO (b) <u>157 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> 19 <u>59</u> , to <u>7-10</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-10-1961</u> , and that death occurred at <u>-</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>James R. Martin</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-11-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>				22d. ADDRESS <u>6 SHAW ST. ANNAPOLIS, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7-12-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Annies Cmt</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>				25a. REC'D BY REGISTRAR <u>JUL 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7539
CERTIFICATE OF DEATH

07530

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY in lb <u>4</u> years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1729 E. Federal St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Isabel</u> First Middle Last <u>REED</u>		4. DATE OF DEATH <u>July 29</u> Month Day Year <u>1961</u>		5. SEX <u>F.</u> 6. COLOR OR RACE <u>N.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 18, 1889</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State, or for country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>REED Samuel</u>		14. MOTHER'S MAIDEN NAME <u>ELSON Emma Mae</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMATION Address <u>Medical Record Department</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis and Septicemia</u> 7/15 X DUE TO <u>Decubitus Ulcers.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration and Cachexia.</u>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 17</u> 19 <u>57</u> to <u>July 29</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 29</u> 19 <u>61</u> , and that death occurred at <u>10:07</u> PM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Lonel McHenry Mapp</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Lonel McHenry Mapp</u>				22d. ADDRESS <u>Crownsville State Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-2-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Anne Arundel Co., Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>RANDOLPH COLLUICK</u> ADDRESS <u>1412 E. PRESTON ST</u>				25a. REC'D BY REGISTRAR <u>AUG 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>			

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BRADSHAW COLLEGE - 1911 - 1912

1 FOR STATE HEALTH DEPT.

TO **DUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO **FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
7540 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07531									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Jessup c. LENGTH OF STAY IN b 1 month d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Old Jessup Rd					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Wayne Edward Renfrow					4. DATE OF DEATH Month May Day July Year 32 1961				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3 1961		9. AGE (In years last birthday) 2 yrs. IF UNDER 1 YEAR 19 Months IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Albany, Indiana			12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Iloff Neal Renfrow					14. MOTHER'S MAIDEN NAME Ruth Anne Coplin				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. No		17. INFORMANT SP4 and Mrs. Iloff N. Renfrow Address (Parents)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation 724.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Head was caught between mattress and crib rail								INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Head was caught between mattress and crib rail						
20c. TIME OF INJURY 3:30 Hour XX M. 7/22/61 Day 19 Year p.m.			20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Jessup (County) AA (State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Gustave H. Faubert					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Gustave H. Faubert MD					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					Address (Street, city, town, or county) Glen Burnie				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 25, 1961			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Byrnenille Cem.		22d. LOCATION (City, town, or country) (State) Byrnenille Indiana		
23. FUNERAL DIRECTOR See with Sonoran Laurel, Md.					24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks		
					DATE JUL 31 '61				

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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7541 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07532

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>D.O.A. ANNE ARUNDEL GENERAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>West Lanthan Hills, Md</u> d. STREET ADDRESS <u>7727 Surroull</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KATHARINE LEE Rickenbacker</u> First Middle Last 4. DATE OF DEATH <u>7 23 1961</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec 16 - 1944</u> 9. AGE (In years last birthday) <u>16</u> 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>school</u> 11. BIRTHPLACE (State or foreign country) <u>Washington DC</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Arthur John Rickenbacker</u> 14. MOTHER'S MAIDEN NAME <u>Helen Lee Rose</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Helen Lee Rickenbacker Hyattsville Md</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Sudden</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Swimming on Benedict's Beach</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>7.23 1961</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>AA Co MD</u> 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Lohardt</u> EXAMINER'S NAME (Type) <u>E. Lohardt</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7.23.61</u> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7/26/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u> 22d. LOCATION (City, town, or country) (State) <u>Colmar Manor, Md.</u>		23. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u> 24a. REC'D BY REGISTRAR <u>JUL 27 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

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01332

DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2281

FOR STATE
RECORD

(M)

(1)

[Faint, mostly illegible handwritten text, likely a medical certificate or report. Includes phrases like "I hereby certify", "Cause of death", and "Signed" followed by a signature.]

COM. ST. 1. 2001

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07533

7542

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROSE HAVEN</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Abraham</u> Middle <u>Rose</u> Last <u>Rose</u>		4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9 1889</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u> Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant-Amusement</u>	
11. BIRTHPLACE (State or foreign country) <u>Roumania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Solomon Rose</u>		14. MOTHER'S MAIDEN NAME <u>Sarah BENDICT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Joseph Rose</u> Address <u>Rose Haven 220 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> <u>Cardiac disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (a), stating the underlying cause last. DUE TO (c) <u>Sudden</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7-6-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 9-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Sharon</u>		22d. LOCATION (City, town, or county) (State) <u>Springfield Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24a. REC'D BY REGISTRAR <u>Jul 10 '61</u>	
ADDRESS <u>Annapolis Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Khand</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK - BUREAU OF HEALTH

FILE NO. 100-100000

NAME OF DECEASED	DATE OF DEATH	PLACE OF DEATH
JOHN J. SMITH	10/15/1968	100-100000
AGE	SEX	RACE
45	M	W
EDUCATION	RELIGION	DATE OF BIRTH
High School	Catholic	10/15/1923
DATE OF DEATH	PLACE OF DEATH	DATE OF DEATH
10/15/1968	100-100000	10/15/1968

CAUSE OF DEATH	DATE OF DEATH
Myocardial Infarction	10/15/1968
DATE OF DEATH	PLACE OF DEATH
10/15/1968	100-100000

DATE OF DEATH	PLACE OF DEATH
10/15/1968	100-100000
DATE OF DEATH	PLACE OF DEATH
10/15/1968	100-100000

DATE OF DEATH	PLACE OF DEATH
10/15/1968	100-100000
DATE OF DEATH	PLACE OF DEATH
10/15/1968	100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7543

07534

1. PLACE OF DEATH e. COUNTY Anne Arundel <div style="text-align: right;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY a.a. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore d. STREET ADDRESS 6020 Belle Grove Rd			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN b 7 ye, 7 mo 27 days				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital							
3. NAME OF DECEASED (Type or print) First William Middle Rose Last Rose		4. DATE OF DEATH Month 7 Day 23 Year 1961					
5. SEX Male	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/1888	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 7 Days 23		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown Contractor		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown George Rose			14. MOTHER'S MAIDEN NAME Unknown Susie Ann ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown No			16. INFORMATION 219-03-1651 unknown Hospital Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Chronic Brain Syndrome Assoc. with Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 8 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 11/19 19 53 to 7/23 19 61 that (I) (we) last saw the deceased alive on 7/23 19 61 and that death occurred 8:40 a.m. on the causes and on the date stated above.							
22a. SIGNATURE <i>George M. K. Phillips</i> M.D.				22b. ADDRESS CROWNsville Md.			
22c. PHYSICIAN'S NAME (Type) George M. K. Phillips							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 26, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Lukes Cem. Balto. Md.			
23d. LOCATION (Town or country) Balto. Md.		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Kate R. Williams</i>		25a. REC'D BY REGISTRAR Jul 25 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

George M. Phillips
? 1912

CRONINVILLE Md

1. The first part of the document is a list of names and dates, which appears to be a record of some kind. The names are written in a cursive script, and the dates are in a more formal, printed style. The list is organized into two columns, with names on the left and dates on the right. The names are: John Smith, James Brown, William Jones, and Thomas White. The dates are: 1810, 1811, 1812, and 1813. The list is followed by a signature, which appears to be "John Smith".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07535

7544

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY in 1b <u>3 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital, Annapolis, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Laura HALLETT SANDERS</u>		4. DATE OF DEATH Month <u>7</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8 June 1876</u>	
9. AGE (in years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George HALLETT</u>		14. MOTHER'S MAIDEN NAME <u>Katie LYNCH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mary H. SCOTT, P.O. Box 34, Mayo, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of bladder and</u> DUE TO <u>fecal-urinary fistula</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7 July</u> , 19 <u>61</u> to <u>10 July</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10 July 1961</u> , and that death occurred <u>9:15 PM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Stephen B. Nittalide</u> M.D.	
22b. DATE SIGNED <u>10 July 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>U.S. Naval Hospital, Annapolis, Md.</u>	
22d. ADDRESS		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/12/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of Sorrows</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. REGISTRAR'S SIGNATURE	

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
7545					07536				
inf. on items 13 & 14 from birth certificate									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 3 hrs		2. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital					d. STREET ADDRESS 19 College Creek Terrace				
3. NAME OF DECEASED (Type or print) SELLMAN		First		Middle		Last		4. DATE OF DEATH July 6 1961	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1961		9. AGE (In years last birthday) 3 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Arthur Alvin Sellman					14. MOTHER'S MAIDEN NAME Rosie Elizabeth Naylor				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Immaturity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) 4 hrs (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (Deceased) attended the deceased from July 6, 1961 to July 6, 1961 that (I) (see) last saw the deceased alive on July 6, 1961 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Dr. A. T. Allen					22b. DATE SIGNED 12:30 P.M.		22c. ADDRESS 62 Cathedral St., Annapolis, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8 July 1961		23c. NAME OF CEMETERY OR CREMATORY Hopes Chapel Cm.		23d. LOCATION (City, town or county) (State) Edgewater Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese II				ADDRESS 108 W. Wash. St. Ann.		25a. REC'D BY REGISTRAR JUL 11 '61		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	

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7546 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 13 & 14 Film G292 8/15/61 iwk
CERTIFICATE OF DEATH

Reg. Dist. No. 07537

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel, MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pennsylvania</i> b. COUNTY <i>Lloydell</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shadyside</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>None 75X-3</i>	
3. NAME OF DECEASED (Type or print) <i>Rudolph Daniel Silberhorn</i>		4. DATE OF DEATH <i>July 12 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 7, 1890</i>
9. AGE (In years last birthday) <i>71 yrs.</i>		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Catholic Priest</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>M. S. A.</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>unknown</i>	
14. MOTHER'S MAIDEN NAME <i>unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Rev. Charles White, Crookston, Pa.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>on July 12, 1961</i> , 19____, that I last saw the deceased alive on <i>July 12, 61</i> , 19____, and that death occurred at <i>6:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Willard F. Smith</i> M.D.		ADDRESS (Street, city or town, state) <i>Shadyside, Md.</i> DATE SIGNED <i>7/12/61</i>	
PHYSICIAN'S NAME (Type) <i>WILLARD F. SMITH, MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/17/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph's</i>	22d. LOCATION (City, town, or county) (State) <i>Beaverdale, Cambria, Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. L. Donnelly</i> ADDRESS <i>Beaverdale Pa</i>		24a. REC'D BY REGISTRAR <i>7-14-61</i>	24b. REGISTRAR'S SIGNATURE <i>Lauram Dimond</i>

JUL 31 '61

Arthur L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO PUBLIC HEALTH DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]	
AGE [Handwritten: 45]		DATE OF BIRTH [Handwritten: 10/15/1891]	
PLACE OF BIRTH [Handwritten: Boston, Mass.]		OCCUPATION [Handwritten: Clerk]	
MARITAL STATUS [Handwritten: Married]		DATE OF MARRIAGE [Handwritten: 05/10/1915]	
NAME OF DECEASED'S MOTHER [Handwritten: Mary Doe]		NAME OF DECEASED'S FATHER [Handwritten: John Doe]	
NAME OF DECEASED'S SPOUSE [Handwritten: Jane Doe]		DATE OF DEATH [Handwritten: 11/20/1937]	
PLACE OF DEATH [Handwritten: Home]		CAUSE OF DEATH [Handwritten: Heart Disease]	
MEDICAL HISTORY [Handwritten: Hypertension, Diabetes]		PRESENT ILLNESS [Handwritten: Angina pectoris]	
PHYSICIAN'S SIGNATURE [Handwritten: Dr. J. Smith]		SIGNATURE OF DECEASED'S NEAREST RELATIVE [Handwritten: Jane Doe]	
PHYSICIAN'S ADDRESS [Handwritten: 123 Main St, Boston]		ADDRESS OF DECEASED'S NEAREST RELATIVE [Handwritten: 456 Elm St, Boston]	
CITY [Handwritten: Boston]		STATE [Handwritten: Mass.]	
COUNTY [Handwritten: Suffolk]		DISTRICT [Handwritten: North]	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the Registrar of Vital Statistics, State House, Boston, Massachusetts.
 The date of death must be given in full, and the cause of death must be given in full, and the name of the physician or coroner must be given in full.
 The name of the deceased must be given in full, and the name of the nearest relative must be given in full.
 The address of the deceased must be given in full, and the address of the nearest relative must be given in full.
 The city, state, and county must be given in full, and the district must be given in full.
 The physician's signature and address must be given in full, and the signature and address of the nearest relative must be given in full.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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3
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7547
CERTIFICATE OF DEATH

07538

1. PLACE OF DEATH a. COUNTY <u>Crownsville A.A. County</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>since 4/1/59</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> f. COUNTY <u>Balto</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>2509 Madison ave. Balto Md</u> d. STREET ADDRESS <u>2509 Madison Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Smith</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1888</u>
9. AGE (In years last birth <u>73</u> yrs.)		IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Balto Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Rubin Pake</u>	
14. MOTHER'S MAIDEN NAME <u>Minnie Pake</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart failure</u> DUE TO <u>334X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal failure -</u> DUE TO (c) <u>CBS & atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7-13-61</u> <u>7-15-61</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS and CNS lines.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>e.m.</u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-17-1959</u> to <u>7-15-1961</u> that (I) (we) last saw the deceased alive on <u>7-15-1961</u> , and that death occurred at <u>6pM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Hildegard Heard Reissman</u> M.D.		22b. DATE SIGNED <u>7/17/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissman, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/20/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DeWaters mem pk</u>	23d. LOCATION (City, town or county) (State) <u>Balto Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Mutter</u> ADDRESS <u>3035 W. North Ave</u>		25a. REG'D BY REGISTRAR <u>JUL 24 61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7548

07539

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby</u>		First <u>SOLLERS</u> Middle Last		4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-13-61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>2</u> yrs.		11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co., Md.</u>	
13. FATHER'S NAME <u>William PARKER</u>		14. MOTHER'S MAIDEN NAME <u>Ida Lucille Sollers</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT <u>William PARKER Hospital files</u>		Address <u>Lothian, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>13 July</u> , 19 <u>61</u> , to <u>15 July</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>14 July</u> , 19 <u>61</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James I. Hudson, Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>21 July 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>James I. Hudson, Jr., M.D.</u>				22d. ADDRESS <u>South River Medical Center, Edgewater, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>July 15, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ADAMS CHAPEL</u>		23d. LOCATION (City, town or county) (State) <u>LOTHIAN, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>T A Hardesty + Son</u> ADDRESS <u>Galesville, Md</u>				25a. REC'D BY REGISTRAR <u>JUL 19 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. [unclear]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7549

CERTIFICATE OF DEATH

07540

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 601 Oaklawn Ave.,			
3. NAME OF DECEASED (Type or print) Thomas				4. DATE OF DEATH July 16 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 27-1894	
9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Beaches		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Spriggs				14. MOTHER'S MAIDEN NAME Harriet Owens			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Harriet Gant-601 Oaklawn Ave. Anna, Md.			
17. INFORMATION Harriet Gant-601 Oaklawn Ave. Anna, Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) Solar Phlemonia following (b) Post-operative for Septic Adenoma of the (c) Sigmoid Colon; Anteriorly placed Heart PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Pulmonary Edema			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 16 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (do not) attended the deceased from June 14, 1961 to July 16 1961 , that (I) (do not) last saw the deceased alive on July 16, 1961 , and that death occurred at 11:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE R. L. Richardson				22b. DATE SIGNED 7/17/61			
22c. PHYSICIAN'S NAME (Type) R. L. Richardson				22d. ADDRESS 110 Clay St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-20-61		23c. NAME OF CEMETERY OR CREMATORY Chews Chapel		23d. LOCATION (City, town or county) (State) A.A.Co. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks 111				25a. REC'D BY REGISTRAR JUL 21 '61			
ADDRESS Annapolis, Maryland				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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Journal of Management Education

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THE AUTHOR'S ADDRESS

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7550 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07541

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel,</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>District of</i> b. COUNTY <i>Columbia</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deale</i>				c. LENGTH OF STAY IN TB <i>one day</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>18 Washington, D.C.</i> 47X-			
				d. STREET ADDRESS <i>1841 A St., SE</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>John</i> First <i>WALTER</i> Middle <i>Stover</i> Last				4. DATE OF DEATH <i>July</i> Month <i>7</i> Day <i>1961</i> Year			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 9, 1906</i>	
				9. AGE (In years last birthday) <i>54</i> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MECHANIC</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Auto</i>		11. BIRTHPLACE (State or foreign country) <i>HARRISONBURG VA.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>RALEIGH STOVER</i>				14. MOTHER'S MAIDEN NAME <i>NELLIE RALLS</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16. SOCIAL SECURITY NO. <i>UNKNOWN</i>			
				17. INFORMANT <i>RUTH May Stover-1841-A St SE WASH DC</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Unusual exertion (Lifting boat anchor)</i> INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>years</i>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Willard F. Smith</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>WILLARD F. SMITH, MD</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <i>7/10/1961</i>		22c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>Switzland Rd. R660 Co., MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers</i>				ADDRESS <i>6-517-1195 SEWYH DC</i>		24a. REC'D BY REGISTRAR <i>DATE 11 '61</i>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7551

CERTIFICATE OF DEATH

Reg. Dist. No. 07542

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Weems Creek) Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Weems Creek, Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>631 Ridgley Ave.</u>				d. STREET ADDRESS <u>631 Ridgley Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SUSAN AUSTIN BILLINGS TEEPLE</u>				4. DATE OF DEATH Month Day Year <u>JULY 16 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 30, 1866</u>	
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N.Y.</u>	
13. FATHER'S NAME <u>John Punderson Ballings</u>				14. MOTHER'S MAIDEN NAME <u>Ann Eliza Kuykandall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs Ernest E. Brooks, Daughter same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Senility</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Brooklyn, N.Y.</u>				20g. (County) <u>Brooklyn, N.Y.</u>		20h. (State) <u>Brooklyn, N.Y.</u>	
21. I certify that I attended the deceased from <u>5-19</u> , 19 <u>52</u> , to <u>7-16</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>7-16</u> , 19 <u>61</u> , and that death occurred at <u>5:17</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>45 Franklin St, Annapolis Md</u> DATE SIGNED <u>7-17-61</u>							
ACTUAL SIGNATURE <u>Edith Rodler M.D.</u>				PHYSICIAN'S NAME (Type) <u>Dr. Edith Rodler</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>July 20, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreens Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Brooklyn, N.Y.</u>				22e. (State) <u>Brooklyn, N.Y.</u>		22f. (City, town, or county) <u>Brooklyn, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 21 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>				24c. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7552 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07543	
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Epping Forrest c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) River View Trail						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Epping Forrest d. STREET ADDRESS River View Trail e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First EDITH Middle MARGAHTA Last THIEL						4. DATE OF DEATH Month July Day 24 Year 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 8th 1920		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME				11. BIRTHPLACE (State or foreign country) NEW YORK CITY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME NILS ERIKSON						14. MOTHER'S MAIDEN NAME EDITH ZETTERBERG					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -				16. SOCIAL SECURITY NO. -		17. INFORMANT ROBERT I. THIEL Address (2)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 410X IMMEDIATE CAUSE (a) Rheumatic Heart Disease with Mitral and Aortic Valvular Stenosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Petty				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 7/25/61			
EXAMINER'S NAME (Type) Charles S. Petty, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7-26-1961		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cmt		22d. LOCATION (City, town, or country) Bladensburg Md		(State)			
23. FUNERAL DIRECTOR John M. Saylor Sons Annapolis Md				ADDRESS		24a. REC'D BY REGISTRAR JUL 26 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

M

Chronic lead disease with lead and lead
Valley, Virginia

Robert J. Hunt

2

Female

South

Harvard

Third

River View Trail

Booth's Point

Booth's Point

and Annual

Annual

Annual

01543

2552

Charles S. Terry, N.Y.

1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

7553

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville State Hospital</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Valley Lee</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>18x-2</u>	
3. NAME OF DECEASED (Type or print) First <u>TURNER</u> Middle <u>T.</u> Last <u>THOMPSON</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-24-44</u>
9. AGE (in years, if UNDER 1 YEAR, last birthday) <u>16</u> yrs. Months <u>18</u> Days <u>2</u> Hours <u>7</u> Min. <u>18</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Valley Lee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Turner T. Thompson, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>18x-2</u>	
17. INFORMANT <u>18x-2</u>		Address <u>18x-2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Circulatory Insufficiency - Shock</u> <u>Pneumonia</u> 493X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>Pneumonia</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>18x-2</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> e.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-28</u> , 19 <u>59</u> , to <u>7-9</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-9</u> , 19 <u>61</u> , and that death occurred at <u>7:25</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Addison W. Pope</u> M.D.		22b. DATE SIGNED <u>7-9-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>ADDISON W. POPE MD</u>		22d. ADDRESS <u>Crownsville State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/12/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. George's</u>	23d. LOCATION (City, town or county) (State) <u>Valley Lee Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>McClarke Mattingley</u>		25. REC'D BY REGISTRAR <u>Arthur S. Kenna</u>	
ADDRESS <u>Leonardtown, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	
DATE <u>JUL 11 '61</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

(M)

(T)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7554

07545

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Shadyside			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Alfred Middle D. Last Tubb				4. DATE OF DEATH Month July Day 14 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-27-88	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 7 Days 14		IF UNDER 24 HRS. Hours 10 Min. 50			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer				10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (County & State, or foreign country) Birmingham Ala.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Dwight Tubb				14. MOTHER'S MAIDEN NAME Viola Frayle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. 577 10 3521			
17. INFORMANT Mary Louise Tubb Shadyside Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia (terminal) 162. } DUE TO 162. Bronchogenic carcinoma of left upper lobe of lung Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO metastases to left ventricle of heart (c) over one year						INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Dec. 2 1960 July 14 1961	
21. I certify that (I) (this hospital) attended the deceased from Dec. 2 1960 to July 14 1961, that (I) (we) last saw the deceased alive on July 14 1961, and that death occurred 10:50 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Willard F. Smith				22b. DATE SIGNED 7/14/61			
22c. PHYSICIAN'S NAME (Type) Dr. Willard Smith				22d. ADDRESS Shadyside, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 7-15-61		23c. NAME OF CEMETERY OR CREMATORY Johns-R. Nat'l Funeral Home Birmingham Alabama		23d. LOCATION (City, town or county) (State) Birmingham Alabama	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty				25a. REC'D BY REGISTRAR DATE JUL 19 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

07543

07543

(M)

James Marshall

Marshall

Shawnee

Shawnee

James Marshall General Hospital

Illinois

Tomb

July 11

61

Male White

11-27-88

12

Bright Tomb

Shawnee

07510 5000 Mary Louisa Shawnee

(1)

10:50

A.M.

Shawnee, Mo.

Dr. J. H. Smith

James Marshall General Hospital
Shawnee, Mo.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7555

07546

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville				c. LENGTH OF STAY IN 1b 14/4.4 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Norwood Nursing Home				d. STREET ADDRESS Box 322			
3. NAME OF DECEASED (Type or print) Margaret L. Wagner				4. DATE OF DEATH Month July Day 15th Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/85	9. AGE (In years lost birthday) 76 rs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John H. Robinson			14. MOTHER'S MAIDEN NAME Mary A. Rush				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Margaret L. Miller (daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Insufficiency 421.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Unknown ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? NO
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore, Md.		(County) Calvert		(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 4/28/61 19____, to 7/15/61 19____, that (I) (we) last saw the deceased alive on 6/15/61 19____, and that death occurred on 8.30 P.M. the causes and on the date stated above.							
22a. SIGNATURE Gustave H. Faubert, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/15/61	
22c. PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.				22d. ADDRESS Glen Burnie, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/18/1961	23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City, town, or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				25a. REC'D BY REGISTRAR DATE JUL 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17548

DEPARTMENT OF COMMERCE

17548

Annex

(M)

Division

(1)

May 1, 1914

Box 100

May 1, 1914

May 1, 1914

May 1, 1914

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CERTIFICATE OF DEATH

Reg. Dist. No.

07547

7556

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Acton Place</u>				d. STREET ADDRESS <u>14 Acton Place</u>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>WALTERS</u> Last				4. DATE OF DEATH Month <u>JULY</u> Day <u>2</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 11, 1903</u>		9. AGE (In years last birthday) <u>57</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prop.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Amusement Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Morris Walters</u>			
14. MOTHER'S MAIDEN NAME <u>Fannie Novabetsky</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>215 07 6279</u>				17. INFORMANT <u>Mrs Dena Walters- Wife- Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Carcinomatosis</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Lung</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 mrs.</u> <u>?</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb. 15, 1961</u> to <u>July 2, 1961</u> , that I last saw the deceased alive on <u>July 2, 1961</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>July 3, 1961</u>							
ACTUAL SIGNATURE <u>Maruice F. Klawans</u> M.D.				DATE SIGNED <u>July 3, 1961</u>			
PHYSICIAN'S NAME (Type) <u>Maruice F. Klawans MD</u>				ADDRESS <u>31 Southgate Ave., Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 4, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kneseth Israel</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis, Maryland c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4502 Frederick Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond E. Yantz		4. DATE OF DEATH Month July Day 2 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1899
9. AGE (in years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 6 Days 2	
11. IF UNDER 24 HRS. Hours 1 Min. 4		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George S. Yantz		14. MOTHER'S MAIDEN NAME Jeannette Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Mrs. Janet R. Yantz		Address 4502 Frederick Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 1 day 1 yr			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
21. TIME OF INJURY Hour a.m. Month, Day, Year 19	22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	22f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-2-1961 to 7-2-1961 , that (I) (we) last saw the deceased alive on 7-2-1961 , and that death occurred at 8:58 PM from the causes and on the date stated above.			
22a. SIGNATURE James R. Martin M.D.		22b. DATE SIGNED 7-2-61	
22c. PHYSICIAN'S NAME (Type) JAMES R. MARTIN		22d. ADDRESS ANNAPOLIS, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF July 5, 1961	23c. NAME OF CEMETERY OR CREMATORY Hillcrest	23d. LOCATION (City, town or county) (State) Cumberland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker & Sons		25a. REC'D BY REGISTRAR Baltimore, Maryland DATE JUL 3 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

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